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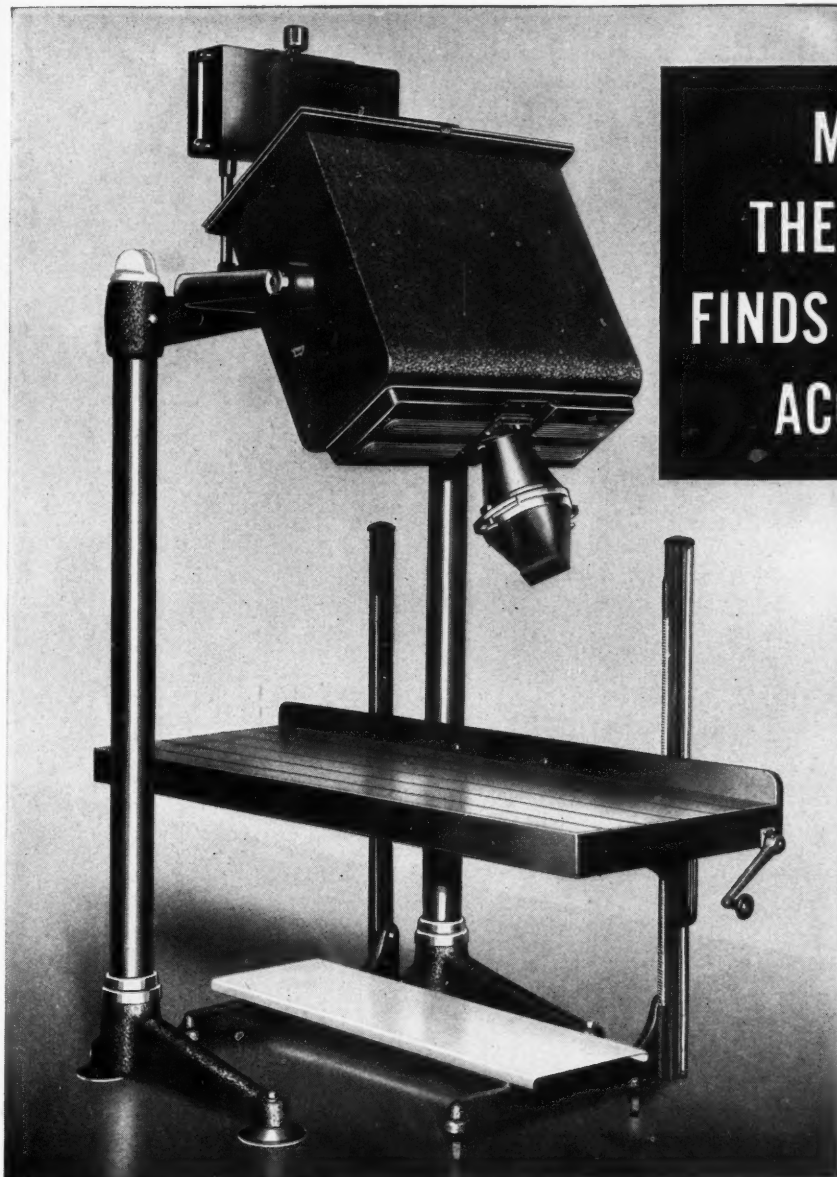
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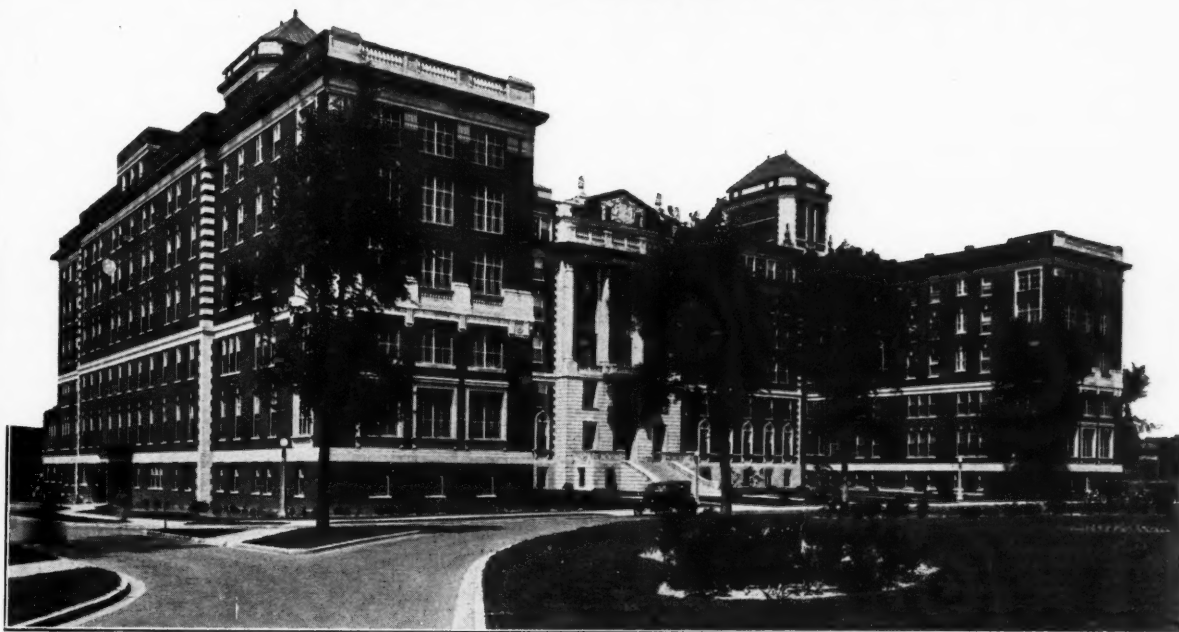
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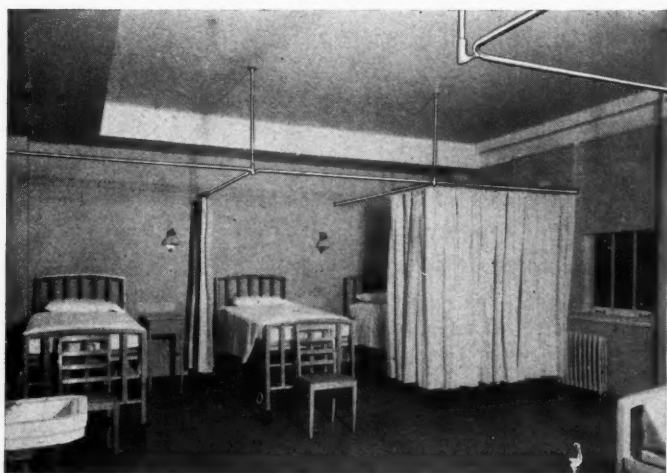
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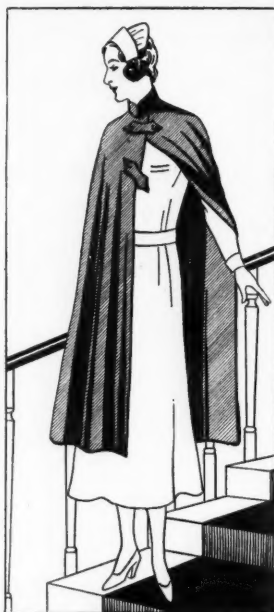
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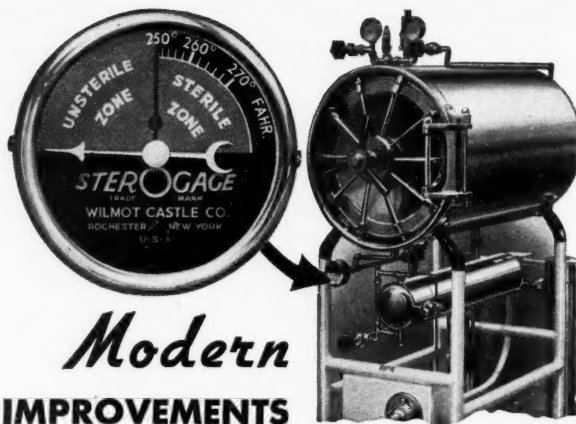


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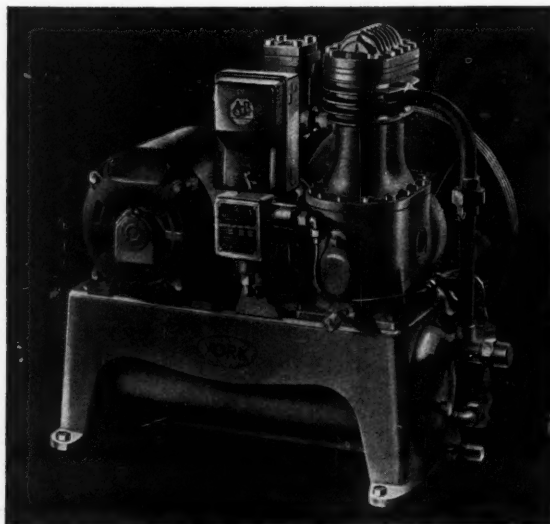
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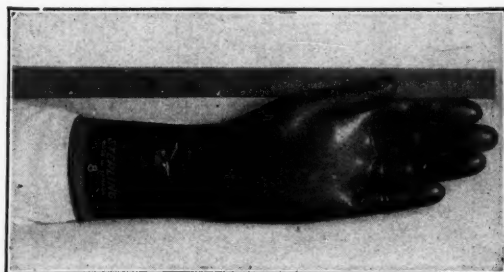
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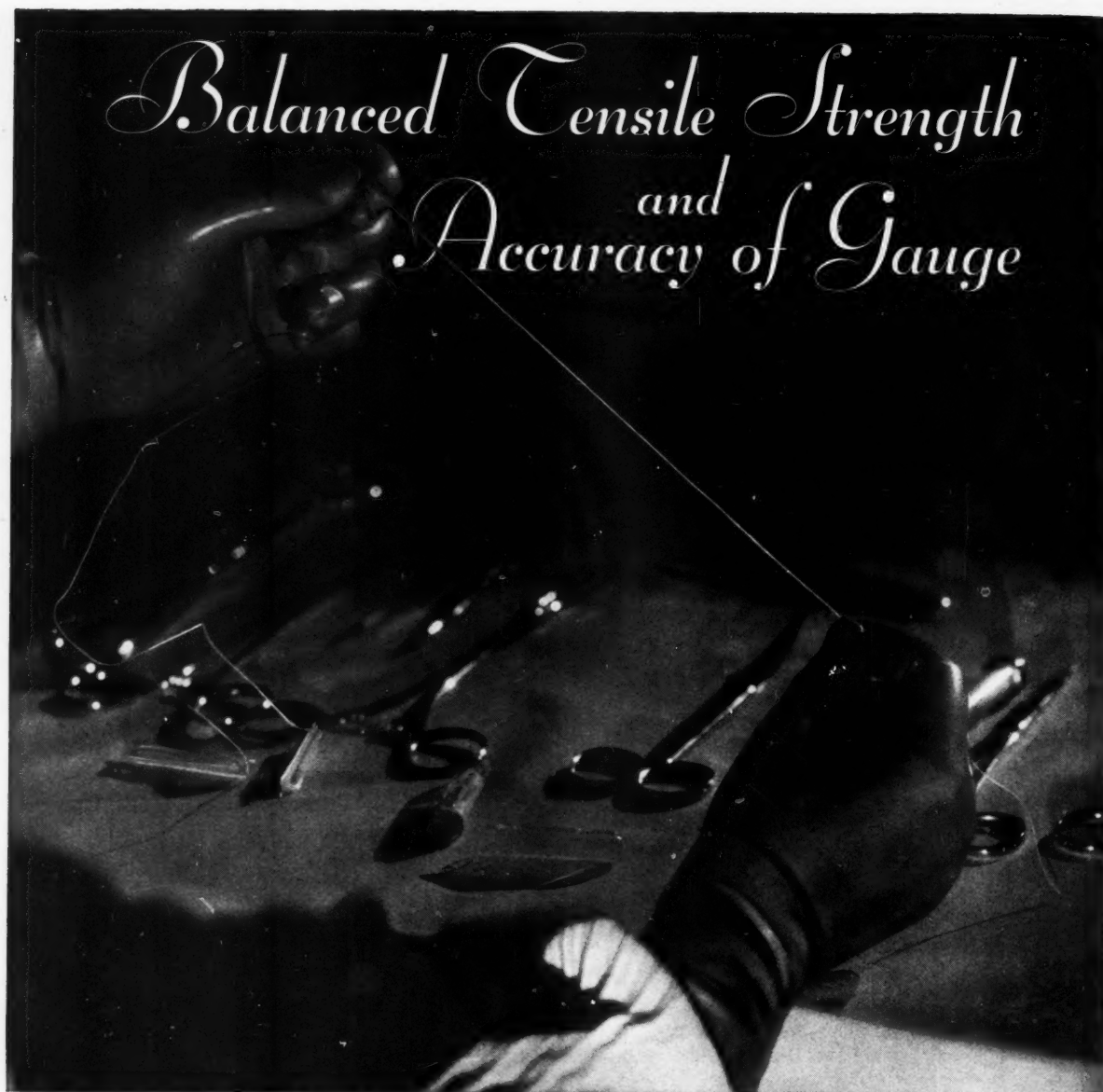
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# The Idea of a Clinical-Pathological Museum\*

By WILLIAM BOYD, M.D., M.R.C.P. (Edin.), F.R.C.P. (Lond.)

Professor of Pathology, University of Manitoba

EVERY museum must express, no matter in how halting a form, some dominant idea. It is the concrete embodiment of the concept in the mind of its creator. A pathological museum is commonly regarded as a receptacle for gross diseased specimens, and the great museums of the world, those priceless storehouses of rare and instructive material, are organized on this basis. But the concept of pathology may be of wider scope than this. It has a functional as well as an organic side. It is concerned with the production of clinical pictures as well as the production of lesions. The demonstration of an adenoma is not the last word in the study of pituitary disease, as is evident from a study of the pictures in MacCallum's beautifully illustrated text-book. Whilst no exception can be taken to the idea of a museum devoted entirely to gross specimens, one may also be permitted the idea of a museum wider in scope, the object of which is to display in addition the microscopic, the clinical, and the radiological aspects of disease. It is this idea which has inspired the work which during the last eighteen months has transformed the museum of the Medical School of the University of Manitoba in Winnipeg, from a strictly pathological into what may be called a clinical-pathological museum. It is the idea embodied in the Wellcome Medical Museum, which so far I have not had the privilege to visit.

The means by which such an end may be attained will vary greatly with the individual worker. I can merely describe the lines along which the work has developed in Winnipeg. The most important single feature has been the introduction of pictures interspersed with the specimens. These pictures represent gross and microscopic sections, almost invariably in colour, animal parasites, blood films, skin diseases, eruptive fevers, diseases of the throat and eye, temperature charts, roentgenograms, electrocardiographic tracings, a great variety of clinical states, and the masters of medicine, both past and present.

In illustration of the general idea we may take a few examples. In the section on Addison's disease in addition to the lesions of the adrenal there is a water-colour painting of a patient showing the characteristic bronzing of the skin, a coloured illustration of the pigmentation of the mouth and tongue, and a picture of Thomas Addison with a short biographical sketch. Graves' disease is illustrated by a picture of a patient with characteristic exophthalmos and enlarged neck, the gross specimens of the thyroid, the microscopic picture, and a representation of Robert Graves with the usual biographical notes. The first specimen in the section on Bright's disease is a picture of Richard Bright with a brief account of that remarkable man. Not only the old masters are represented, for Harvey Cushing's picture appears amongst the brain tumours, Aldred Scott Warthin's in the section on syphilis, Maude Abbott's in that of congenital heart disease, and so on.

The source of the picture has been varied. The richest supply of gross pathological illustrations has been the

magnificent atlas of morbid anatomy brought out more than thirty years ago by Kast, Fraenkel, and Rumpel, with full pathological descriptions and summaries of the clinical histories in German, English, Italian and Russian. The beauty and life-like character of the illustrations have to be seen to be believed. Another excellent collection of pictures of gross specimens is the Atlas published by the *British Journal of Surgery*. For microscopic illustrations in colour extensive use has been made of Christeller's beautiful atlas of sections of whole organs and of Woodhead's book on Practical Pathology which contains 275 illustrations of microscopic preparations in colour. Old editions of many other textbooks, especially that of MacCallum, have been used to a like purpose. A valuable source has been reprints of articles from current literature.

A vast storehouse of clinical pictures is to be found in the old editions of text-books on medicine, surgery, neurology (Purves Stewart's Lectures on The Diagnosis of Nervous Diseases, in particular), ophthalmology, skin diseases, etc. Some of the finest of these illustrations will be found in Byrom Bramwell's Atlas of Clinical Medicine, to which Osler used frequently to refer. Text-books on ophthalmology are particularly rich in coloured plates, not only of the various pictures revealed by the ophthalmoscope, but also of the external lesions of the eye. Most of these plates are used in the section on diseases of the eye, but some are placed in other sections. Thus albuminuric retinitis is to be found in the section of nephritis, choked disc in that of brain tumours, the distended retinal vessels of polycythaemia vera in that of blood diseases, and so on.

X-ray pictures have proved to be a valuable adjunct in teaching the student to view disease as a whole, large negative prints being used in each instance. Alongside the specimens of cancer and ulcer of the stomach he sees the characteristic filling defect or crater revealed by the X-rays. The specimens of bronchiectasis become more living when placed beside a characteristic lipiodol picture of that condition. Hydronephrosis, gall stones, stricture of the oesophagus, and the distortion of the ventricles in cerebral tumour, are amongst the many lesions which lend themselves to radiographic illustration.

Temperature charts are used where the fever presents a more or less characteristic picture, as in pneumonia, typhoid, malaria, and in the section of the eruptive fevers.

A novelty which has proved of value in teaching is what we have termed the "composite picture." In this various aspects of the clinical and pathological features are combined in one frame. As many as 7 or 8 small pictures may be included behind a glass measuring 10 by 12 inches. Thus in the case of pernicious anaemia we have pictures of a characteristic blood film, of reticulocytosis, of normoblasts and megaloblasts, of the gross appearance of the hyperplastic marrow and of its microscopic appearances of phagocytosis of red cells in the marrow, of hemosiderin deposit, in the liver, of another macrocytic anaemia (sprue), and of the spinal cord degeneration. In tabes we

\*Reprinted from Journal of Technical Methods and Bulletin of the International Association of Medical Museums, 1935, xiv, 10-18.



have the degeneration of the posterior columns (Weigert - Pal stain), the tabetic gait, the muscular hypotonia, the zones of anaesthesia, the occasional ataxia of the upper limbs as shown by the tremulous handwriting, the optic atrophy, and the Charcot joint. (Fig. 1.) In the composite picture of typhoid fever one sees the intestinal ulcers, the early and late microscopic changes in the Peyer's patches, the characteristic macrophages, and the bacilli in the mucosa.

In Winnipeg the teaching of pathology is divided between two years. In his second year the student studies such general pathological processes as circulatory disorders, inflammation, tuberculosis, syphilis, tumours, the degenerations, neoplasms, and animal parasites, whilst in the third year the lesions of the individual organs and systems are considered. The museum, which occupies two rooms, is accordingly divided into two sections, one on general and the other on special pathology. The larger room devoted to Special or Systematic Pathology measures 93 feet by 30 feet (Fig. 2); the smaller room on General Pathology measures 72 feet by 30 feet. The second year students use the smaller room only, but the third year men use both. In the general pathology

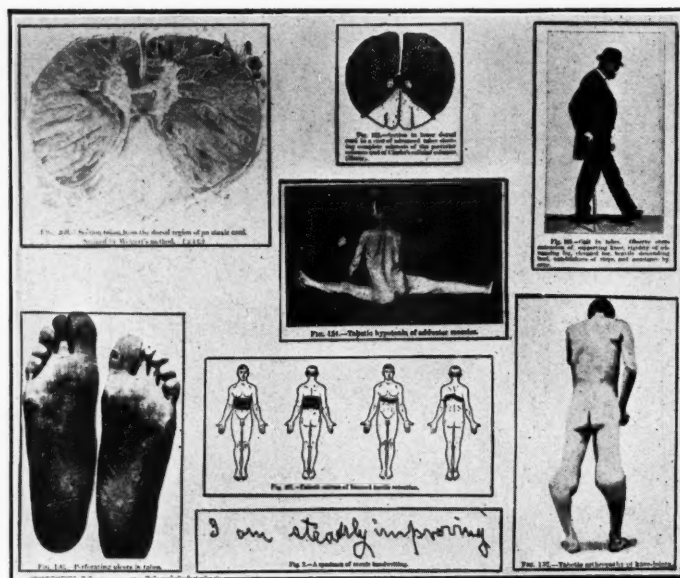


Fig. 1.—Composite picture of tabes dorsalis, showing the pathological lesions and some of the clinical features.

pig, coloured drawings of the various skin reactions, and portraits of Laennec, Villemin and Koch. In the section on syphilis there is a wealth of illustrative material in various atlases, and the student can become familiar with the different cutaneous manifestations as well as with the spirochæta pallida both stained and in the dark field. Portraits of Schaudinn, Ehrlich and Wassermann serve to emphasize how recent are the most important advances in our knowledge of this disease. The degenerative processes lend themselves particularly well to demonstration by means of coloured plates, whereby the various staining methods for fat, fatty acids, amyloid, mucin, glycogen, calcium, etc., are continually before the eyes of the student.

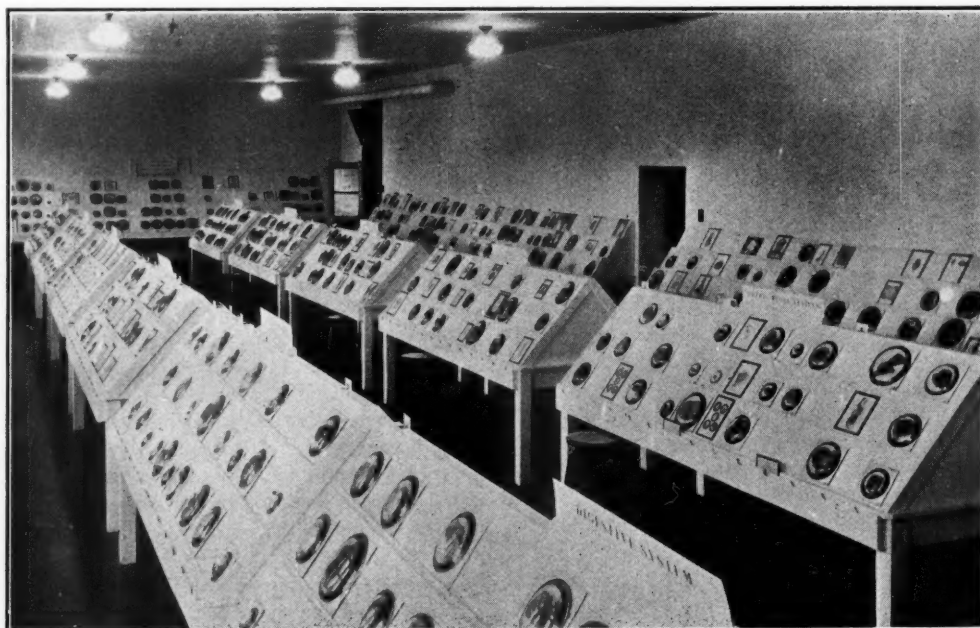


Fig. 2.—Part of the room devoted to Special Pathology.



So much for the general arrangement and the ideas which have served as guiding principles in the construction of the museum. A few words now as to the method of display. Here again there has been a general principle, namely, to make the museum an attractive place where the student may spend one or more hours without feeling fatigued. For this purpose it is necessary that the student be seated. Moreover, the natural and restful position in which to study a specimen or picture is the position in which a book is held to be read. With this in view the standard type of museum showcase has been replaced by a stand constructed in the form of a reading desk. (Fig. 3). Each stand is 10 feet long, 4 feet wide, and 5 feet high, but of the 5 feet, 3 feet are occupied by the legs. The stand faces both ways, holds 84 specimens (42 on each side), and is painted white. It contains three sloping shelves, the centre one being on a level with the eye of a man sitting on one of the numerous stools with which the room is provided. These sloping shelves are not adapted for museum jars, but are admirably suited for watch glasses and pictures. The vast majority of the specimens have therefore been transferred into watch glasses. It is remarkable how large a specimen the largest size of watch glass will accommodate. Both cerebral hemispheres can easily be displayed in this way. Certain specimens will obviously not lend themselves to this treatment, notably those with any great degree of depth, but we have designed a stand on similar lines to the above for the comparatively small number of specimens which require large deep jars. The only difference is that the shelves are horizontal instead of sloping.

One of the great advantages of this type of museum show case or stand is that it lends itself admirably to the display of pictures, temperature charts, X-ray prints, etc. These are covered by old X-ray plates from which the film is readily removed, and bound with passe-par-tout. They are distributed among the watch glasses in the section to which they belong.

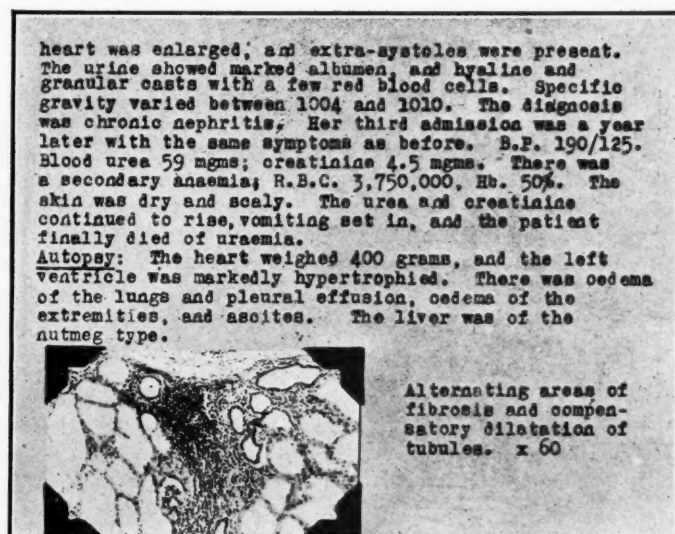


Fig. 4.—Back of catalogue card with microphotograph.

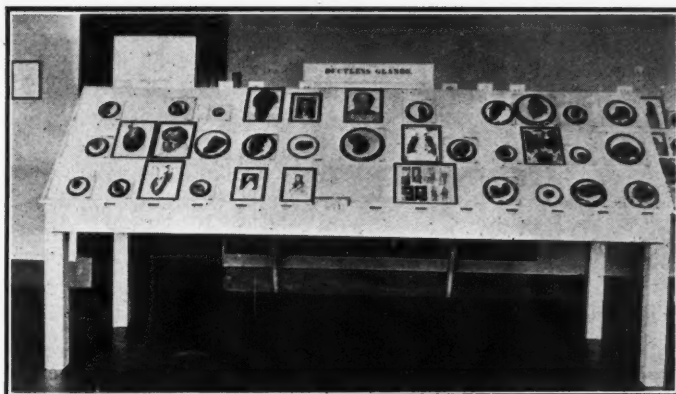


Fig. 3.—Museum stand containing watch glass specimens, clinical pictures, x-ray negative prints, and portraits of the masters of medicine. The pictures in the top row to the left of the centre represent Addison's disease, Graves' disease, and myxedema. The portraits in the bottom row are those of Addison and Graves. The top of the descriptive cards (black) can just be seen.

The method of cataloguing has already been described in Number XIII of this *Bulletin*. It is a combination of the usual short descriptive card and the full length catalogue. The following extract from my former paper gives the essential features of the system. "Along the entire length of the stand and attached to the lowest tier there runs a thin board, 11 cm. in depth, which is set 8 mm. from the stand. In this way a narrow box is provided which is divided by transverse partitions corresponding in size with the largest of the watch glass specimens. This holds a stout card, 5 inches by 7 inches in diameter, on which can be typed everything that would be contained in the catalogue, *i.e.*, description of the specimen (gross and microscopic), summary of the clinical history and autopsy findings. Both sides of the card are used and more than one card may be employed if necessary. A microphotograph or a reduced X-ray picture are attached to the back when considered desirable. (Fig. 4) Three of these cards

are contained in each receptacle corresponding with the three specimens immediately above on the stand." The autopsy or surgical number is placed at the top of the card so that the graduate student can consult the original history if desired.

An additional feature is the use of museum "markers". A marker is a strip of iron painted gold bronze which lies on the stand and serves to separate one set of specimens from another, *e.g.*, rheumatic heart disease from subacute bacterial endocarditis. As there are three shelves there are three markers between each of the sections. This system makes it very easy to see at a glance the exact limits and contents of any given section.

Such a museum does not for a moment pretend to displace the great pathological collections of the older medical schools. It does represent, however, as far as we in Winnipeg are concerned, a new arrangement, new in method of display, in material shown, and in mode of

cataloguing. Moreover it represents an attempt to illustrate in graphic form for the student the principle of correlation which in Winnipeg we have found useful in the teaching of pathology, correlation of the gross and microscopic lesions with the clinical and X-ray picture. That the attempt has been in a measure successful is indicated by the fact that whereas formerly students had to be driven to visit the museum, now they are to be found there in large numbers whenever they have a spare half-hour. Often they spend an entire afternoon there, reading

their text-book and comparing its statements with the illustrations of disease exhibited on the shelves. Even the clinicians are coming to realize that the museum is a storehouse of clinical pictures as well as of specimens of diseased organs. The possibilities of such a museum are unlimited, and it may be made the centre of teaching in the medical school. As Robertson pithily remarks in a paper along very similar lines: "it may thus be possible to elevate the stone that has been almost rejected to become the head of the column."

## Anaesthesia and Our Western Hospitals

By BEVERLY C. LEECH, M.D., C.M., F.I.C.A.,

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THE present decade, so unprecedentedly rich in achievement of medical advance, has contributed nothing more important or spectacular than the progress which has been made in the understanding and practice of anaesthesia.

### Historical Comment

Broadly speaking, the practice of anaesthesia remained almost unchanged from the time of the discovery of general anaesthesia by Morton, Long and Wells, about ninety years ago, until very recent years. Ether or chloroform were administered to the surgical patient in more or less haphazard fashion by whoever could be most conveniently spared to enact this relatively unimportant and facile role, so considered. The effect was usually a horrible and struggling induction with ether, or a sledge-hammer type of induction with chloroform followed by moments or minutes of breath-taking alarm and concern, on the part of all present, as to whether the patient was going to survive this mighty, heroic assault. And the result was most often a very up-and-down sort of anaesthesia, not conducive of good surgery; a horrible, restless and long-drawn-out period of recovery, for the patient; and often distressing after-effects and severe illness, very little understood by anyone in attendance, and all too often ending in disaster.

Of course some became rather proficient in the art of anaesthesia, but generally speaking medical men who endeavoured to study and improve existing methods were soon forced to abandon the field of anaesthesia and take up some line of work wherein the financial return was more on a par with other forms of medical practice. Thus the administration of these dangerous poisons was largely relegated to technicians, nurses, or junior interns; and hence the obvious reason for anaesthesia's falling a half century behind in the general advance of medical knowledge and practice.

### Modern Anaesthesia

But to-day the picture has changed remarkably and will continue to change just as dramatically for years to come.

Now, instead of the surgical patient walking in fear and trembling into the operating room to be confronted with an array of every conceivable implement gathered together deliberately for his personal torture, he finds himself getting drowsy in his own bed, and either submits to the beckonings of Morpheus, or enters such a comfortable state of well-being and euphoria that he pays no heed to his surroundings nor to the gentle onset of anaesthesia in the operating room. This, of course, is accomplished by the anaesthetist's well chosen preliminary medication, which must be specially adapted to the individual patient, and tempered by the anaesthetic and surgical procedures which are to follow.

Now the patient does not have the old time battle with two or three husky attendants while the anaesthetic drug is forcing him into the depths of unconsciousness. On the contrary, the induction is without his knowledge, or is at most a rather welcome approach of warm, deep slumber.

Now the surgical ward is never in mad disorder and uproar due to the thrashing, yelling and vomiting of one or several patients recovering from anaesthesia, as well as probably the moaning and wailing of one or more facing, in apprehension, a similar ordeal. More frequently the patient awakes quietly in his own bed, often asking why his operation has been postponed, or when it is to take place—this even after such major procedures as gall bladder and stomach operations, or even leg amputations.

Now, too, the surgeon and the anaesthetist have such a wide choice regarding the safest anaesthetic agent for the particular patient, combined with the method of administration which will permit the freest, easiest, and therefore best, work on the part of the surgeon, that better surgery is the rule. More intricate and delicate procedures can be successfully undertaken; and many more poor-risk patients can receive beneficial surgical measures heretofore denied them.

And now, also, post-operative pneumonia and other sequelae usually attributed to the anaesthetic are the rarest of rare occurrences.

### Contributory Factors

This great change in the field of anaesthesia has taken place gradually and is constantly spreading. The factors which have contributed toward it are as follows:

1. The demand from the more highly specialized surgeons for anaesthesia more suitable to their particular field of work.

2. The scientific study of modern hospital records, and compiled statistics, has focused the attention of large hospitals and hospital associations on the great problem of reducing post-surgical mortality and morbidity.

3. The splendid efforts of hospital survey and standardization organizations to spread the gospel of accurate records and organized hospital departments—anaesthesia in most larger centres is now a hospital service, similar to the departments of X-ray and Pathology, and manned by a medical staff under an experienced medical director.

4. Pharmacologists and anaesthetic experts in almost every medical centre both on this continent and in Europe are, and have been, particularly for the past decade, devoting a great deal of energy, in quiet and painstaking research, to the discovery, investigation and proving of new anaesthetic agents and methods (as well as putting the older agents on trial for their lives), by every known laboratory, animal and clinical test. It is becoming next to impossible for even one devoting himself exclusively to anaesthesia to follow all this research because of its ever increasing volume in medical literature. Last year, for example, in our hospital of only 400 beds we found we had employed twenty-two different anaesthetic agents given by nineteen different methods.

5. Tremendous strides have also recently been made in the improvement and refinement of the many pieces of technical equipment required for the various forms of modern anaesthesia administration. Just to mention one example: whereas gas-oxygen anaesthesia used to cost, for materials alone, approximately five dollars per hour, it can now be administered by the latest gas machines far more efficiently at a cost for materials of fifty cents or less per hour.

6. And lastly, but not least in importance, is the fact that the anaesthetist is gradually being accorded better recognition as to his place of importance on the surgical team; and his fees are being slowly brought more into line with the relative value of his services. Actually the anaesthetist is beginning to assume his proper position as physician-in-charge of the patient through a very dangerous crisis during which the surgeon is completely engrossed in his intricate work. The anaesthetist must not only maintain a satisfactory, smooth anaesthesia during the whole course of the operation, but he must also constantly diagnose the patient's condition, keep an eye on the amount of blood-loss, administer stimulants, etc., and even occasionally demand that the operation be not proceeded with further. He is dispensing any one of a group of extremely dangerous lethal poisons, and has spent probably years of study backed by experience toward acquiring his knowledge and skill, not to mention the expense of frequent study-travels to keep himself efficient and up-to-date. Surely a fair fee is therefore fully justified and well earned.

### Our Resulting Power

The foregoing observations must lead us to realize that if we hope to keep on doing surgery in our hospitals we must constantly and consistently strive to supply both the patient and the surgeon with better anaesthesia; or at least to provide anaesthesia comparing more favourably with that available in larger medical centres. And this must apply, in graduated scale, to all, from the largest urban institutions to the smallest rural hospitals.

Let us consider more in detail how we can set about this task of improving the status of anaesthesia in our hospitals of various sizes and classes.

Here it might be well first to glance briefly at the legal aspects of the practice of anaesthesia. Speaking generally, in all the provinces of Canada the administration of an anaesthetic is considered to involve "diagnosing" and "prescribing" as well as administering; and hence must be carried out only by a qualified and licensed medical practitioner. For any deviation from this practice someone must be prepared to accept responsibility. This "someone" is primarily the surgeon-in-charge. He is legally in charge of everybody and everything in the operating room during his operation, and he should realize his responsibility in engaging the anaesthetist. In the case of apprenticing interns, who are undergraduates or graduates in medicine without license, these men, or sometimes women, are of course performing their given duties as servants, somewhat under the protecting cloak of the hospital; but at the same time the hospital would be negligent if it did not fully acquaint the surgeon concerning the non-licentiate status of any intern before his being engaged to administer an anaesthetic. And as for nurses giving anaesthetics, the surgeon would have to prove the existence of extremely extenuating circumstances before a court could condone such procedure—it would be, legally, quite on a par with engaging a layman off the street.

So, broadly speaking, from the hospitals standpoint, the following legal aspects are important:

1. The surgeon is in control during the operation and must be prepared to answer for everything that goes on.

2. If the surgeon has employed a licensed physician as anaesthetist, then he has pretty well taken care of that portion of his responsibility. If he has engaged anyone else, then he should appreciate accurately in advance where all responsibility lies.

3. The status of all interns should be explained to all surgeons who might engage them for anaesthetic administrations.

4. In a case where the hospital has knowledge that a certain physician, although qualified, is careless or inebriated, by alcohol or drugs, the hospital is responsible if he is allowed to practice anaesthesia in the institution.

5. Otherwise, where anaesthesia is practiced by a licensed physician, the hospital is freed of all responsibility in so far as anaesthesia administration is concerned.

6. Hospitals must, however, be considered primarily responsible for the quality and reliability of all agents or apparatus supplied by them for the administration of anaesthesia within the institution.

### Suggested Solutions

Now, apart from any legal or minimum requirements,



what is to be expected of our hospitals to-day in keeping abreast of advances in anaesthesia?

#### *The large hospitals:*

First of all, there are five hospitals in this province, wherein general surgery is practised, each having from 180 to 410 beds. Each hospital in this group would do well to organize and equip a department of anaesthesia, as a hospital service on a par with the departments of radiology and pathology. Only one hospital of this group is so organized, and has been for seven years. Such a department should have at its head a director who is an expert in anaesthesia, and who limits himself more or less completely to that line of work. Briefly, the director's duties, aside from the actual giving of anaesthetics are: (1) supervising the training personnel, equipment and supplies of his department; (2) supervising the pre-operative examination of all patients requiring anaesthesia, estimating their grade of risk, ordering suitable preliminary medication, selecting the most suitable and safest type of anaesthesia, and appointing, if not himself, some other member of his staff who is capable to handle the job; (3) supervising the keeping of adequate records and the compilation of statistical reports, particularly as regards complications, etc., for periodic perusal by the medical staff; (4) and a final and important duty is that of keeping abreast of the recent developments in anaesthesia by constant study and frequent travel. Various types of financial arrangements may be tried out with him until one is arrived at which is satisfactory to both the hospital and the director.

The balance of the staff can be made up in different ways depending upon the local situation. One good plan is to appoint two or three associate anaesthetists who make a minor hobby of anaesthesia and who are available to fill in whenever required, and to supervise the department during any absence of the director. Another suggestion is to engage a senior, experienced intern as a one-year resident in anaesthesia—someone who desires to later establish himself as an anaesthetic specialist. Then the addition of one or two interns, on a two or three month rotating service, completes the essential staff personnel.

A great deal can truly be said concerning the benefits of such an organized department of anaesthesia. Even the financial aspect can be worked out to the benefit of all concerned. I know of no instance where an anaesthetic department, once organized, has ever been later dissolved.

#### *Hospitals of Lesser Size:*

There are nine hospitals in Saskatchewan, each with from 50 to 135 beds, wherein some modification of the above scheme might be instituted. One, I believe, has commenced it. For example, some one doctor who is interested and relatively expert in anaesthesia can, on some minor financial scheme, be appointed as official hospital anaesthetist. He would make it his particular business to supervise the anaesthesia interests of the hospital and make a special effort to keep himself efficient and well informed in matters of anaesthesia, and adopt as many of the principles of larger departments of anaesthesia as might well be worked into his particular institution.

For the remaining smaller hospitals, of which there are, I believe, 53 represented in this association, I would strongly recommend that the constant improvement of anaesthesia be given frequent consideration. They could urge upon their attending doctors the desirability of having some one of their number make a hobby of anaesthesia and become the hospital advisor in such matters. Such a man could pay occasional short visits to a near-by large hospital where there exists an organized department of anaesthesia, and where, I assure you, he would be made welcome. He could thus keep himself fairly well-informed concerning new developments, etc., and might thus help to solve some of the problems of his local institution.

In conclusion, permit me to urge that all hospitals would be well-advised to stay well within the bounds of mere legal requirements. They should do much more than this by way of promoting the cause of safe and satisfactory anaesthesia. After all, pain relief and pain prevention are the most humanitarian functions in the whole broad field of medical service.

\*Presented at the Saskatchewan Hospital Association Convention, Saskatoon, Nov. 19th, 1936.

## **American College of Surgeons to Hold Regional Meetings in Canada**

Announcement has been made by the American College of Surgeons that Sectional Meetings are to be held during 1937 in Edmonton, Alberta; Atlanta, Georgia; Seattle, Washington; and Denver, Colorado. A fifth meeting is contemplated in Halifax, Nova Scotia, but the arrangements for this have not as yet been completed.

The Edmonton meeting will be held at the Macdonald Hotel on March the 24th and 25th. A very attractive program is being arranged. Operative and non-operative clinics will be held in local hospitals during the mornings, and it is anticipated that there will be special clinics on Cancer and Fractures. There will be major scientific sessions in General Surgery and in Eye, Ear, Nose and Throat. Approved motion pictures demonstrating surgical

diagnosis and technique will be shown.

Hospital conferences will be held during the first two days of each meeting. These conferences will afford opportunities for the presentation of papers and discussions and of departmental demonstrations in the local hospitals.

Community health meetings are being arranged for each of the sections. These should attract large audiences.

An extensive series of talks to luncheon clubs and to business and professional organizations is being arranged. These addresses will deal with the progress of scientific medicine, prevention of disease, good hospital care and other topics of public interest. In addition, speakers will appear before high school assemblies, and radio broadcasts are being arranged. The annual meeting for the Fellows of the provinces represented will be held on the afternoon of the first day, and it is anticipated that there will be scientific and technical exhibits.



# A Symposium on "Hospital Charts"

- I. The Record Librarian's Viewpoint (this issue)
- II. The Medical Viewpoint (February)
- III. The Legal Viewpoint (March)

## I. The Record Librarian's Viewpoint

By MISS ISOBEL MARSHALL, R.R.L.,  
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**G**OOD hospitals have a three-fold function. The primary function is, of course, the care of the sick, and the efficient performance of this function is the duty of the professional and associated staffs of the hospital. The second function of a well organized hospital is the instruction of house physicians and undergraduate nurses. The capable performance of this function constitutes the contribution of the hospital to the general medical welfare of the public at large. The third function, one not to be overlooked in any efficient hospital, is that of investigation and research. Abstruse scientific research, of course, demands much scientific equipment and well staffed laboratories, and this is possible only in a few of the larger institutions. But clinical research and the investigation of the results of the use of various types of therapy is possible in any hospital, where there is adequate clinical material, and where the system of keeping records is such as to render statistics reliable. The hospital, which is capably performing these three functions, will be an efficient hospital, and will be making a definite contribution towards the advancement and improvement of methods of caring for the sick. It will best accomplish this if its records are so prepared and kept as to make this contribution possible and valuable.

### The Importance of a Good Record

The chart plays an extremely important part in the functioning of a well organized hospital. The quality of the medical care given the patient is likely to be in direct relationship to the care exercised in the keeping of records. Primarily, of course, this is the responsibility of the physician in charge and of the house physician under him. In the training of the nurse and intern, a properly kept record is a "sine qua non". Carelessly prepared records strongly argue carelessness in the observation and management of the case. No nurse or intern should be graduated from a hospital without having had it impressed on her, or him, the importance, not only of accurate observation of the patient, but of accurate recording of these observations. Hospital administrators are seized of the importance of this feature in the training of nurses and interns.

### The Record Librarian

The record librarian has an extremely important part to play in the realization of this ideal. The condition of the records of a hospital may be taken as an index of its efficiency. The records must be kept in such condition as

to assist in the carrying out of the three functions of a good hospital. The record librarian does not make the record. Her duty begins when the record is complete. If she is to build in her record room, the structure which will best serve her institution, she must have good material with which to build. It will be remembered that in olden times the Children of Israel found it very difficult to "Make Bricks without straw". It is equally difficult for the record librarian to keep her records in efficient shape if her raw material, in the form of the hospital chart, lacks straw. Therefore, if she is capable and efficient, she should exercise such an influence on the preparation of the raw material as to enable her to constantly improve the character of the structure which she is building for her institution.

### Composition of the Record

Let us now consider the raw material. Neatness and legibility in the preparation of the chart are extremely important. The lack of these essentials entails much loss of time on the part of the record librarian. If she must constantly consult interns in order to have scrawls deciphered, she is not only delayed, but discouraged. Care in the setting down of data regarding age, family history, and so forth, is very necessary, and the necessity is so obvious that this point need not be stressed. A systematic record of the results of physical examinations, according to some definite plan, makes her work here interesting and less difficult. Laboratory and X-Ray reports should be attached to the chart while it is still on the ward, and it is no part of the duty of the record librarian to have constantly to call the laboratory, X-Ray department or ward to secure these highly important accessories to the record.

Laboratory and X-ray records should be written clearly and in good English, and the use of abbreviations and laboratory slang should be avoided. Nothing detracts so much from a laboratory report as the use of poor English, and abbreviations and expressions difficult to understand. Doctors, nurses and laboratory technicians should be diplomatically urged to avoid falling into this error.

One of the most essential parts of the chart is that which deals with progress notes. Properly prepared progress notes give a good historical outline of the progress of the case and should never be omitted from a hospital chart. They naturally must be made by the intern in

charge of the case, and should not be left to the nurse. The nurse has her own notes to make, and her notes should give a detailed account of the treatment and nursing of the case. They should in no way replace the progress notes to be made by the intern. It is annoying at times to note the size of the chart of a patient who has spent some weeks or months in the hospital, only to find on examination, that it consists almost entirely of nurses' notes, and that the progress notes are scanty or absent. To obviate this difficulty, the suggestion has been made that, while in hospital, a separate file should be kept for the nurses' notes. The intern would be thus constantly reminded of his duty in this regard by the emaciated condition of his own file. The vital principle, in making records of cases of illness, and especially of making records of patients in hospital, is that notes cannot be adequately made from memory. The busy intern, with many patients under his care, naturally cannot carry long in his mind the details of the progress of any particular patient, and he will find it much better in the interests of his patient, of his own training, and of the record room, to make notes promptly, day by day, or at whatever intervals are best suited to the case. One cannot stress too much the importance of regular and adequate notes to the well-kept chart and to the well-treated patient.

The charts of surgical patients present also a problem, which is at times difficult. This difficulty is increased sometimes in the case of busy surgeons and private patients. Nevertheless, the care and trouble necessary in the securing of complete records of surgical procedures, and of the leaving of drains and their removal, will often be amply repaid later, if it should happen that the case gets into the Courts. Suits for malpractice and in connection with insurance matters make this feature doubly important. The Courts lay great stress on the hospital records as an evidence of the efficiency of the management of the patient, and it is very hard for the physician or surgeon to establish the fact that certain therapeutic or other measures have been carried out if these are not properly recorded on the charts. Many suits are lost through the omission of proper entries. The record librarian must be constantly on the alert when the chart comes to her to see that this has been done, and to this end she must have the full co-operation of the intern staff and of the administrative officials of her hospital.

#### Completing the Record

The prompt completion of the chart, and its prompt return to the record room on the discharge of the patient, or death of the patient, is of great assistance. Delay, not only renders the task of completing the chart more difficult, but is less satisfactory because human memory is so fallible. Most interns can be trained to carry out this duty efficiently if proper diplomatic measures are taken at the beginning of their term of service. Once trained in the routine of the prompt return of the chart to the record room, they find it a pleasant duty. Their work in this regard does not pile up, and the necessary entries do not fade from their memories. More and more demands are being made on hospitals for Government returns, which require accurate diagnoses of cases, and with this in view, the necessity for prompt completion of the chart and diagnosis becomes obvious.

In the case of the patient who dies in hospital, a further addition to the chart is necessary in the form of an autopsy report. This report, of course, can in many cases be furnished by the pathological department within a few hours of death, but there are certain cases where a longer period of study is necessary. Bacteriological, chemical and microscopic examinations may be essential to a correct diagnosis. These take time. Most pathologists, of course, do not need reminders, and all pathologists are only too delighted to have the record librarian keep in close contact until the work is finally complete.

#### Ownership of the Record

The chart is hospital property, and must remain in the charge of the hospital. The staff, the interns and the doctors who practice in the hospital must be brought to realize this. It is to the advantage of themselves and their patients to have the properly completed record always available. For this reason, charts should leave the record room only for the most urgent reasons. Charts to be used in Court cases will, of course, be requisitioned by Court order, and will be taken to Court in charge of a hospital official. After use, they will be returned. With this exception, there will be very few reasons why the chart should leave the record room. Of course, charts should always be available, and for this purpose the record room should provide reasonable facilities. If such facilities are provided, there will be very little trouble over the matter of having charts removed and kept out, and no reason at all for having part or all of the chart lost. This should be thoroughly understood by the patient, the hospital and the doctor.

With most record rooms, there arises the problem of furnishing copies of charts to insurance companies and to the other agencies entitled to have them. This, of course, is to some extent an expense to the hospital; a nominal charge for this service is usually made, and it is the question of payment of this charge which gives difficulty. One feels that, in the case of insurance companies and other bodies who ask for copies, the fee should be paid by them, and negotiations between them and the patient concerned taken up later. This is a matter which should be studied in the interests of the efficiency of record room work.

In conclusion, it may be stated that the preparation of the hospital chart and its filing constitute one of the most important duties of any hospital. The properly prepared chart is a record of the management of any case of illness in the hospital, and argues good care of the patient, good training of nurse and intern as well as facilities for clinical research. The chart is the raw material of the record librarian, and if this material is too raw, the structure will not be up to the standard desired. The chart should be legible and accurate. Laboratory notes should be kept up to date. The chart should be promptly returned to the record room, and should not leave it except under unusual circumstances, provided for by the regulations of the hospital.

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Presented at the Annual Meeting of the Association of Medical Record Librarians of Ontario, Toronto, October 22nd, 1936, in a symposium on "The Hospital Chart".

# SOCIAL SERVICE WORK

## and the Rome Convention of the International Congress of Catholic Nurses

By REV. JOHN E. BURNS,  
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ON August 25th-29th, 1935, was held at Rome a convention of the International Congress of Catholic Nurses. The delegates to the convention numbered about two thousand, and represented twenty-seven nations. Of this number about half were religious and half lay-nurses. Meetings of the entire convention were held in the great Consistorial Hall over the narthex of St. Peter's Basilica, while sectional and national groups met in smaller rooms in the Vatican Palace. Religious exercises in connection with the convention were held in the Basilica of St. Peter's, in the Catacomb of St. Domitilla, in the Coliseum, and in other places of religious and historical importance. The delegates were received in special audience by His Holiness Pius XI at Castel Gondolfo, his summer residence.

Prominent speakers, both clerical and lay, addressed the delegates. Through these speakers, and through the contacts made with persons from all parts of the world, those present came in touch with world problems. Hence the resolutions they drew up at the convention are worthy of the closest study.

We must give them our attention at this convention because this is the first time we have met since the Rome convention. Likewise our convention is devoted to the study of social service problems, to which subject the Rome convention gave considerable thought, and with which the most important of its resolutions is concerned.

The Congress resolved that, being "called by the Grace of God to works of Charity, they wish to show the Charity of Jesus Christ, to procure the "Peace of Christ in the reign of Christ" and to be faithful to their motto "to love, and edify and help one another," and by their works and their cares and joyous sacrifices they wish to impress their dear sick, the indifferent, and even their enemies, with the truth that they love them and seek only their happiness.

The resolution gives emphasis to the virtue of charity, and recalls St. Paul's words to the Corinthians.

If I speak with the tongues of men, and angels, and have not charity, I am become as sounding brass and tinkling cymbal. And if I should have prophecy, and should know all mysteries, and all knowledge, and if I should have all faith, so that I could move mountains, and have not charity, I am nothing. (I Cor. XIII.)

It recalls also the words of Leo XIII in *Rerum Novarum*, where, after the Pope had traced with a masterly hand the course the world must follow if it wishes to restore justice, he concludes as follows:

... the happy results we long for must be chiefly brought about by the plenteous outpourings of Charity; of the true Christian Charity which is the fulfilling of

the Gospel law, which is always ready to sacrifice itself for the other's sake, and which is man's surest antidote against worldly pride and immoderate love of self; that Charity whose office is described and whose God-like features are drawn by the Apostle St. Paul in these words: "Charity is patient, is kind . . . seeketh nor her own, . . . suffereth all things, . . . endureth all things."

Piux XI, writing forty years after *Rerum Novarum*, speaks in the same way, saying that to bring about the reforms he desires "charity 'which is the bond of perfection' must play a leading part".

Unfortunately the word "charity" has acquired an unpopular sense. People say: "We do not want charity. We want justice." By justice they mean a chance to live and work their way. But as a matter of fact they want something more than justice. They want the benefit of that feeling of fellowship with their brother men, that knowledge of security in unity which charity, understood in its true sense, alone can give. Charity is the practical bond of unity among men. It is not a mere act of pity. Against the condescension of pity the needy rebel. It is not a mere joyous giving, for this is selfish, and charity "seeketh not her own." It is a realization of the fundamental unity of men in, to use the strong words of St. Paul, "the bowels of Christ."

Thus charity must be understood in the light of the doctrine of the Mystical Body of Christ. This doctrine, developed by St. Paul, is receiving much attention in recent years. It is explained in many publications, and should be familiar to all those who are to exercise a ministry of charity. It is held to be, in a sense, the keystone to the Christian edifice. It gives to the Mass and to Holy Communion a meaning which would otherwise escape us. It makes the practice of all virtues, but especially of charity, a truly supernatural work. It is the answer to the need of our day for unity in the domain of thought and purpose in the domain of action.

This charity must be the source of our activities. Let it be our prayer that it will always reign in our institutions, not as a light hidden under a bushel, but as one set on the mountain tops, a lesson to all men.

### Training of Nurses

The second session of the convention dealt with the necessity of proper professional training of nurses, and the second resolution, framed after this session, is of interest in this connection.

What the Lord did in His Public Life with regards the sick, the weak, the afflicted, the children, He wishes that they should do, not by means of miracles and preaching, but by rendering service, by example, by devotedness, by kind words. But He does not merely wish them



to assist the body. By the body they must reach the soul.

It is then to gain souls that they will generously undertake the sacrifices that their personal preparation entails and that they will strive to hold their places at the bedside of the sick and the abandoned.

This resolution suggests the following line of thought. We are accustomed to the idea of the priest at the altar carrying on for the people of our day the act which our Lord performed on Calvary. We are accustomed to consider the voice of the authorized preacher as continuing the message which Christ first preached among the valleys of rural Palestine, and in the public places of the Jewish people. We should also realize that the nurse and the social worker are carrying on another phase of His work, namely "what the Lord did in His Public Life for the sick, the weak, the afflicted, the children."

This conception of social work enobles it most highly, and cannot be recalled too frequently. You carry on a tradition of charity which goes back to the ministration of Jesus to the people of His times, which He commenced, for before Him there was no charity, and very little philanthropy. He brought a new thing—charity—into the world.

The last paragraph of the resolution expresses the determination of the convention to do all possible to maintain the place of the religious hospital. It recalls the words of Leo XIII anent the right of the Church to look after the poor and the afflicted.

The Church has everywhere stirred up the heroism of charity, and has established congregations of religious and other useful institutions for help and mercy, so that there can be hardly any kind of suffering which may not be visited and relieved. At the present day there are many who, like the heathen of old, blame and condemn the Church for this beautiful charity. They would substitute in its place a system of state organized relief. But no human method will ever supply the devotion and self-sacrifice of Christian Charity.

#### Social Service Work

Another resolution deals with *social service work*. It is a long one, and will only be resumed here.

Social service exists to bring "the salutary and merciful influence of Christian charity . . . into the family life." It is felt that this is the only way of ministering

to the really poor. No great change can be made in their condition unless the home itself is changed. It is necessary "to make known in the home the Charity of Christ." "What is lacking at the cradle and is not given from the heart of a mother" must be supplied by those who exercise true charity.

We are reminded that the family is the unit of every sound social structure, and in dealing with any kind of people this must be recognized. Otherwise no lasting work of betterment can be accomplished. It is not only the homes of those in good circumstances that are of importance in the life of a people. The homes of the needy have their importance. It is there that the elevation of these people must commence. We must turn a deaf ear to the attacks made on the sanctity of the family. These attacks must be counteracted by striving to make the home more attractive, by teaching the needy to see in it indeed a refuge, where they will find some peace and comfort. Too often they are taught to look for these elsewhere, to go outside the home for their recreation, companionship, and the answer to their smallest needs. In arresting this tendency we are carrying out a truly valuable work not only for religion, but for the state, which is but a collection of homes.

Finally it is in the home that education, commenced in the school, will find its completion. A principle laid down by one social worker was

To help in an "educative" way, and appeal to the active collaboration of those one is helping, to accustom them gradually to get themselves out of their own difficulties.

So much assistance given to the needy is only helping to pauperize them, to make them look habitually for aid from others, instead of inducing them to be independent. Social service work must avoid this error. It must be "educative". Here again the right approach is through the home. The social worker must instil into the needy a conception of the worth of the individual, of the dignity of labour, and of the sacredness of the unalienable rights of the family.

Here then are two principles for the social worker. Restore the home. Educate its inmates. Based on these principles social work will be sound and progressive.

Address delivered to the delegates of the Maritime Conference of the Catholic Hospital Association, and of the Maritime Council of Catholic Nurses, meeting for their conventions in Truro, N.S., July 9th and 10th, 1936.

#### Meeting of Ontario Neuro-Psychiatric Association

The Fall Meeting of the Ontario Neuro-Psychiatric Association was held at the Ontario Hospital, Toronto, on Friday, November 20, 1936, with an attendance of one hundred and twenty-one.

The President, Dr. G. H. Stevenson, Medical Superintendent of the Ontario Hospital, London, was in the chair and the welcome was extended by Dr. R. C. Montgomery, Superintendent of the Ontario Hospital, Toronto. There were several papers and discussions at the sessions. Dr. G. E. Hobbs of the Toronto Psychiatric Hospital, gave a clinical and pathological presentation "Essential Hypertension as a Cause of Mental Disorder." Dr. J. D. Heaslip, Superintendent of the Ontario Guelph Reformatory, gave a sociological study on "The Place of Medicine in the

Treatment of Crime." Dr. Herbert Hyland of Toronto gave an instructive and illustrated talk on "Symptomatology of Frontal Lobe Lesions."

Dr. Samuel Hamilton, Director of the Psychiatric Survey Committee spoke at the afternoon and evening sessions.

Following the afternoon session an Executive Meeting of the Association was held and it was decided that the next and annual meeting of the Ontario Neuro-Psychiatric Association be held at the Ontario Hospital, London, on March 18, 1937, and that the evening session take the form of a Memorial to the memory of the late Dr. Richard Maurice Bucke to commemorate the one hundredth anniversary of his birth.—A. McCausland, M.D., Secretary, O.N.P. Ass'n.



# Obiter Dicta

1937

THE year 1936 with its progress and its problems has gone—throughout the year a thousand Canadian hospitals have daily played their part in the service of humanity, meeting a multitude of problems with that quiet dignity that is so characteristic of our institutional life. As you read this editorial you will most probably be in the midst of reviewing the year's work of your institution—we sincerely hope that your annual statement shows a complete balance, first in service and secondly, in its financial aspect.

Sometimes, and particularly in times like the present, we are apt to concentrate on the dollar and cent angle of our activities but as good administrators we must at all times remember that good hospital care is our one real reason for existence and if we can sincerely say we have achieved this end then it is only right that we then turn to the monetary side to see if we have rendered such services in the most economic manner possible. All too often when drafting our budgets for the year we attempt to either equal or improve the previous years' returns. While this is necessary and reasonably good policy we must not forget that for a number of years we have been cutting our expenditures in an attempt to equalize diminishing collections with the result that salaries and equipment have suffered to a varied extent and that now as we swing towards normalcy again it is necessary to make provision in the budget for readjustment in an upward direction.

For continued good service to the sick, good equipment and a contented staff are vital items, and the wise administrator will face the problem of explaining to the governing body the necessity of increased provision for expenditures in the budget with squared shoulders, knowing that it will be for the ultimate good of all rather than take the easier course of duplicating past year performances which at best have to be considered abnormal. The cost of living is up, the cost of many hospital commodities are up, do not absorb it at the expense of good hospital care. May 1937 be a happy and progressive year to all our Canadian hospitals.



## Museum Work

UNTIL a few years ago, we considered the hospital museum something to be found only in the larger of our institutions and were content to designate it as a storehouse of pathological specimens suitably labelled. To-day we are not so content in accepting this status of museum work and we find in hospitals of almost every size some attempt to preserve, for educational purposes, interesting specimens.

This month we have been permitted to publish, through

the courtesy of Dr. William Boyd of the University of Manitoba, and the Journal of Technical Methods and Bulletin of the International Association of Medical Museums, a reprint of Dr. Boyd's article entitled "The Idea of a Clinical-Pathological Museum". This article should be read by every hospital administrator; for it shows the possibility of every institution being able to prepare exhibits that are of great educational value because of their ability to tell a story.

While admitting that extensive museum work must of necessity be confined to the larger institutions, there is no reason whatever why even the smallest hospital could not prepare at least one interesting and valuable exhibit each month. If this were done, a very few years would see a valuable museum in existence. Such educational work is one of the duties of all hospitals and we sincerely hope that after reading this article, those administrators who, so far, have not considered clinical-pathological museum work for their hospital will be inspired to do something about it.



## Conduct of the Staff Conference

The staff conference, when properly conducted, becomes a large group consultation where the results and experiences of a number of physicians and surgeons are focused on the patient for his benefit. The discussion must be entirely impersonal, free from embarrassment, and characterized by a willingness to pool knowledge for the benefit of all present and particularly for the patient.

A good measure of the success of the meeting depends upon the competence of the chairman. It is his duty to see that the meeting is conducted in a business-like fashion, that deliberations and discussions are keen and to the point, that verbosity is discouraged. In order that every minute may be of intensive interest to all, the cases for presentation must be well prepared and one member of the staff ready to open the discussion. Usually, only a few selected cases can be discussed at one meeting. Each speaker should have a limited time for discussion. When the members present have had ample time to discuss a case the chairman should promptly take up the next one. A case critic to review and summarize the discussions is found by many hospitals to be of advantage.

Recognized parliamentary procedure should govern the meeting but need not be so strictly enforced as to discourage discussion. Parliamentary rules can be used to advantage in quieting the ever-present member who wanders on indefinitely. A very good plan is to set a fixed time for each item on the program, for example: ten minutes for discussion of the monthly analysis report, ten minutes for presentation of each case, five minutes for opening discussion, three minutes for each subsequent discussion.

# Hospitals Urged to Carefully Observe Drug Sales Requirements

**H**OSPITALS are again urged to most carefully observe the requirements, laid down by the Excise Division of the Department of National Revenue, with respect to the sale of drugs and other goods, and the relationship of such sales to the exemption from Sales Tax. As previously pointed out, inspectors from this Department have already visited several large hospitals to check up on their sales of taxable goods obtained free from sales tax for the hospital's own use. It has been found, in some cases, that returns of sales tax have not been made, as stipulated by the Department in 1932. These inspections are to be continued, and hospitals will find that not only will they be liable for arrears of sales taxes since 1932, as determined by the Department, but may be subject to the statutory penalty as well. It would appear that the Government is very anxious to be fair to the hospitals, but a regulation is a regulation, and it is the duty of departmental officials to enforce such.

In the letter from the Commissioner of Excise of January the 28th, 1932, it was stated:

"Having reference to your letter of January 20th and to your interview with the Department on the 25th, concerning the application of Sales Tax to drugs purchased by bona fide public hospitals certified to be such by the Department of Pensions and National Health, I am instructed to inform you that such hospitals will be entitled to purchase free from Sales Tax, drugs for their use in the treatment of indigent patients, and also of those cases where charges are being made to the patient, provided the charge is not greater than the cost to the hospital of the drugs in question, plus 10%.

"In those cases where the addition to the cost of the drugs is greater than 10%, or where sales are made to doctors or others not patients of the hospital, the hospital will be required to maintain a record of the sales made, and account for Sales Tax at the existing rate on the value of such goods sold."

Recently, the Secretary of the Canadian Hospital Council received enquiries concerning interpretation of the regulations with respect to various types of drug sales, such as the sale of drugs to out-patients, to patients treated in the emergency department, to patients referred to the hospital pharmacy by private doctors, to the issuance of syringes, scales, etc., to diabetic patients either while in the hospital or after discharge, and as to whether or not the cost of compounding medicinal preparations could be included in the cost of the preparation itself. The following letter should be carefully read:

"Department of National Revenue  
Excise Division

Ottawa, Dec. 4, 1936

File No. A.C.E.

Canadian Hospital Council,  
184 College Street,  
Toronto 2, Ont.

*Attention: Dr. Harvey Agnew*

Dear Sir:—

Your letter of November 30th, concerning the application of the Sales Tax to hospitals, is acknowledged, and the following information is supplied.

If the out-patient clinic to which you refer is conducted by the hospital itself and the drugs supplied to this clinic are purchased by the hospital and with hospital funds, and the charge made to the out-patients does not exceed the cost of the drugs plus 10%, they would be exempt from tax. This ruling is applicable also to out-patients attending dispensary or out-patient departments of bona-fide public hospitals which have been certified as such.

Your understanding is correct, that where a patient is treated in the emergency department, or by doctors in the hospital who may either be on the staff or merely have offices in the hospital building, and the charge made for the drugs, etc., supplied is more than the cost of those goods plus 10%, the tax applies. If the purchaser is a patient of the doctor only and the doctor purchases the drugs to supply to his patient, the tax applies irrespective of whether they have been sold at an advance of more than 10% or not. In other words, if a doctor merely purchases his requirements of drugs, etc., from the hospital dispensary these are taxable whether for use in his private practice or not, as the hospital is not in a position to certify in such cases that the goods in question are 'for the use of the hospital and not for resale'.

Insofar as the diabetic patients are concerned, equipment, drugs and the like supplied to them would be taxable, if sold at an increase of more than 10% advance on the prime cost of the material sold, whether this was the initial issue to the patient or a subsequent issue.

In reference to the 10%, this is intended to mean 10% of the cost of the drugs or equipment only, and is not intended to be applied on any labour or overhead cost which may be incidental to the compounding, titrating, mixing, etc. In other words, the 10% was intended to mean only this advance on the original cost of the articles or materials being sold, and is not intended to cover any other costs whatsoever.

May I take this opportunity of pointing out that apparently considerable misunderstanding has arisen in connection with the purchase of supplies, etc., by hospitals, and it is evident that sufficient attention is not being given by hospital staffs to the wording of the certificate which they sign on the purchase of the goods. Examples have come before the Department where the hospitals claim to have not received any information or instruction in this regard and large assessments have been made in some cases as a result. It is believed that in some cases hospitals have quoted their certificate on orders for goods which were known at the time to be not for the hospital's own use; also, sales

of equipment (bedding, blankets, and the like) have been made to hospital staffs, doctors, etc., for their private use who purchased through the hospital, probably to obtain better prices, and Sales Tax not accounted for.

Abuses of this nature are, of course, bound to have their reactions, and if your Council can do anything toward promoting a more careful observation of the requirements your co-operation will be appreciated, as, otherwise, it is felt that steps must be taken to safeguard the public revenue.

Yours truly,

(Sgd.) V. C. Nauman,

VCN/Mc

Ass't. Commissioner of Excise."

In a subsequent letter dated December the 18th, 1936, the Assistant Commissioner of Excise clarifies the question of making returns by the following statement: "If hospitals would make returns quarterly of Sales Tax due, say, at the 1st of January, April, July and October, this would be satisfactory to the Department, and would obviate the necessity of monthly returns. The hospitals should make the returns themselves to the local Collectors of Customs and Excise, and should not wait for Departmental auditors to visit them. Forms on which to submit the returns may be obtained from the local Collector's office."

#### Toronto Hospital Darkened Fifty Minutes

Just before Christmas, the new 500-bed Toronto Western Hospital had the experience of being plunged into total darkness for the unusually long period of 50 minutes. A main transformer blew out, and it was some time before the emergency crew of the Hydro Electric Commission could restore power. The hospital was filled, practically to capacity, and, in addition, a large Christmas party for children was being conducted in the solarium on the 14th floor. One of the elevators was stopped near the top of the shaft, loaded with some 13 children, but the operator quickly reassured the children who sang carols until their plight was observed and they were released by some of the staff. Fortunately, no operations were in progress, although the hospital is fully equipped with emergency lighting for such exigencies. The nurses and doctors carried on with candles and flashlights until the power was restored.

#### A Rare Opportunity

Mrs. Andrew Fulton, who, as Miss Ruth Thompson, was Assistant to the Secretary of the Canadian Hospital Council during its early years, contributes to the Canadian Hospital the following advertisement, which recently appeared in a local paper in British Guiana where she is now living:

"WANTED. One good boy as an under-kook, mus' be at w'ok at 5.45 o'clock daily; capable of washing' motor-car, bathin' doggies, keepin' gardens, occasionally carryin' out of baby gal and answer me as Masta. I will make him a man later in life. Pay 1/- per weekly. No Find. Please apply in person at Courida b N. or Courida b S. W."

JANUARY, 1937

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# LOSSES IN COOKING VEGETABLES\*

## Department of The Canadian Dietetic Association

Conducted by  
Ruth Davison Reid, B.A.

James A. Ogilvy's Limited, Montreal

WITHIN recent years the importance in normal nutrition of the so-called protective foods, milk, fruit, vegetables and eggs, has been stressed. Their chief value lies in their mineral and vitamin, and also, in the case of fruits and vegetables, their fibre, content. In preparation for use milk and eggs do not suffer any great loss in food value, and when fruits are cooked their juices are served with them, but vegetables usually receive treatment which materially alters their composition and the extracted materials are discarded in the cooking water. Some vegetables, such as lettuce, are almost always served raw, but the majority require cooking.

The changes in food value which result from various methods of cooking have been studied by many workers, but data are by no means complete either for individual vegetables or for specific losses. To cite an extreme case, Maurel and Carcasagne studied a large variety of vegetables, including potatoes. 100 gm. portions were boiled for about three hours in distilled water with resulting losses of 61% total salts and 54% potassium. As one never cooks potatoes three hours, such work contributes little of practical interest or value. The work here reported was undertaken in the hope of furthering the knowledge of losses when vegetables are attractively cooked, and also of the factors which cause increased losses.

Important as it is to preserve the nutrients, unless the vegetables are attractive they will not be eaten. Therefore, if there must be a sacrifice, it is better that it be in food value than in the pleasing and desirable external qualities. With this in mind, colour, flavour and texture must be considered.

The study here reported included white and sweet potatoes, white and yellow turnips, parsnips, green beans, celery, cabbage and cauliflower.

Investigations were limited to the

\*This report is the result of investigations made at the Department of Household Science, University of Toronto, by Misses L. P. Lockhart, M. L. Nimmo, M. E. Robertson, B. Williamson and M. R. McKellar.

effect of boiling as this is the method most extensively used. It is also the method which causes the greatest losses. The effects of variations of time, size of pieces, proportion of water, soaking, and covering the vessel were points considered.

### Experimental Work

All determinations were made in triplicate and careful attention given to each detail. The boiling was carried out in 600 c.c. pyrex beakers, distilled water was used, the gas flame was regulated to always give as nearly as possible the same amount of heat, and the length of boiling was taken from the time the water began to boil again after the addition of the vegetable.

### White Potatoes

Preliminary tests with white potatoes showed that 2 c.c. water to 1 gm. potato was sufficient for boiling, and this ratio of water to vegetable was used in all cases except when the proportion was doubled to note the effect.

Table 1 gives a summary of the results. It is seen that when the potato was pared and cooked whole, as the length of the cooking period was increased from 20 to 35 minutes, there was an increased loss of total solids, reducing substances, and ash.

The larger the potato the longer time was required to cook it satisfactorily, and in general 30 to 35 minutes was necessary.

When the potatoes were cut in half either lengthwise or crosswise, the losses were increased; (lengthwise cutting causing a greater loss than when cut crosswise), but the time for satisfactory cooking was shortened—20 minutes being sufficient; and the figures show that the average loss for potatoes cut in half crosswise and boiled 20 minutes was no greater than for potatoes cooked whole for 30 minutes, and they were equally palatable.

As one might expect, the losses when potatoes are cooked whole in their jackets were almost negligible.

On the other hand, it was found that, contrary to popular opinion, when whole potatoes were pared and soaked three hours and then cooked, the total loss showed very

WHITE POTATOES—LOSSES IN COOKING USING 2 C.C. DISTILLED WATER TO 1 GM. VEGETABLE

Method of Preparation	No. lots tested	Cooking period	Losses					Remarks
			Total Solids		Glucose as % of veg.	Ash		
			as % of veg.	as % of solids in veg.		as % of veg.	as % of ash in veg.	
Pared and cooked whole	6	20	0.56	.....	0.044	0.13	14.4	Undercooked
	6	25	0.63	.....	0.049	0.16	18.2	Undercooked
	6	30	0.78	3.5	0.055	0.19	20.4	Variable
	6	35	1.28	.....	0.115	0.21	23.6	Satisfactory or overcooked
Pared and cut in half lengthwise	6	15	0.84	.....	0.056	0.19	21.3	Undercooked
	6	20	0.94	.....	0.043	0.21	23.9	Satisfactory
	6	25	1.11	.....	0.059	0.24	26.3	Overcooked
Pared and cut in half crosswise	6	15	0.67	2.6	0.036	0.16	17.0	Undercooked
	6	20	0.78	3.4	0.053	0.18	19.4	Satisfactory
	6	25	0.91	3.8	0.071	0.19	21.1	Overcooked
Whole in skin	6	30	0.06	0.3	0.040	0.01	1.1	Satisfactory
Pared and soaked 3 hrs. before cooking	6	30	0.91	3.7	.....	0.18	20.5	Satisfactory
Pared and whole but 4 water: 1 veg.	5	30	1.09	.....	.....	0.22	24.7	Satisfactory or overcooked

TABLE 1

**SWEET POTATOES—LOSSES IN COOKING USING 2 C.C. DISTILLED  
WATER TO 1 GM. VEGETABLE**

Method of Preparation	No. lots tested	Cooking period	Losses					Remarks
			Total Solids		Glucose as % of veg.	Ash		
			as % of veg.	as % of solids in veg.		as % of veg.	as % of ash in veg.	
Whole, pared	6	min.	%	%	%	%	%	Undercooked Satisfactory Overcooked
	5	15	1.40	4.0	0.52	0.04	9.5	
	5	25	1.83	5.0	0.80	0.05	11.9	
	5	30	2.15	5.7	0.84	0.06	14.6	
Pared and cut in half lengthwise	6	15	2.13	6.6	0.91	0.07	15.5	Satisfactory
Pared and cut in half crosswise	6	15	1.88	5.7	0.78	0.07	14.6	Satisfactory
Whole in skin	6	25	0.11	0.3	0.01	0.01	2.1	Satisfactory
Pared and whole but 4 water: 1 veg.	5	25	2.85	8.8	1.03	0.08	17.8	Satisfactory

TABLE 2

little increase over those not soaked. One must remember, however, that these potatoes were left whole, so that the result obtained does not apply to potatoes thinly sliced or even cut in half before soaking.

With regard to increasing the proportion of cooking water to four parts water to one of potato, the results show a definite increase in losses, and the flavour of the potato was not as good.

#### *Sweet Potatoes*

In the work with sweet potatoes it was found that the same proportions of water as for white potatoes—namely 2 parts water to 1 of vegetable—was sufficient for satisfactory cooking.

Using this ratio of water to vegetable it was found, as Table 2 indicates, that the losses increased with the length of cooking. It should be noted that when the potatoes were cut in half lengthwise the losses in 15 minutes were as great as when the whole potato was cooked 30 minutes; and when cut in half crosswise as great in 15 minutes as when cooked whole for 25 minutes, and these potatoes were not quite as palatable as when the potato was cooked whole for 25 minutes.

When sweet potatoes are boiled whole in their skins, just as with white potatoes, the losses are found to be negligible.

Increasing the proportion of water to vegetable very definitely increases the losses, and although the potatoes were overcooked in 25 minutes, the losses were greater than when the whole potatoes were cooked 30 minutes using 2 parts water to 1 of vegetable.

#### *Parsnips*

In studying parsnips qualitative tests were first made to determine the most favourable proportion of water and the optimum time of cooking. Several people tasted each sample and the consensus of opinion was that the larger the proportion of water the greater the loss of sweetness and flavour, and the more water-soaked the texture became. Two parts water to one of vegetable was insufficient to cover and found un-

satisfactory, but a proportion of three to one was adopted as giving the best results. When the parsnips were cut in small pieces 10 minutes boiling was sufficient, and 15 minutes when they were cut in large fingers—approximately  $2\frac{1}{2} \times \frac{3}{4}$ ". It was late in the season when work was begun on parsnips and in some cases the cores did not become tender even with long cooking, or if cut in small pieces.

For the quantitative work the parsnips were cut in cubes, as well as in the large pieces, and also cut into strips by cutting the large pieces into long thin strips.

The losses as related to the length of the cooking period were deter-

mined with only the large pieces and the table shows that as the cooking period was increased from 15 to 30 and 60 minutes there was a definite increase in the losses. A comparison of the results also shows that the size of the pieces very definitely influences the amount of material lost in the cooking water—practically a quarter of the total solids in the vegetable being lost in 15 minutes, when the parsnips were cut in thin strips.

It was noticed that the reducing substances found in the cooking water and calculated as glucose, formed only a very small per cent of the total solids lost in the cooking water. It seemed evident that soluble carbohydrate must be present in forms other than glucose. Qualitative identification tests showed sucrose and gums to be present. In the case of two lots of vegetables the cooking water was hydrolyzed by means of acid, and as the table shows the original glucose accounted for not quite 10% of the total reducing substances after acid hydrolysis.

#### *White Turnips*

White turnips are one of the mildest of winter vegetables and with proper cooking they have an attractive creamy-white appearance, and a pleasant, slightly spice flavour. They are usually served cut in about  $\frac{3}{4}$ " cubes. Preliminary work showed that if they were to be served in this manner the most attractive and best flavoured product was obtained by cooking the cubes 20 minutes, using four times as much water as vegetable. The use of a larger proportion of water resulted in an inferior flavour, while if less was used the flavour was strong and the appearance impaired. When boiled whole it required 30

**PARSNIPS—LOSSES IN COOKING USING 3 C.C. WATER TO 1 GM. VEGETABLE**

Size of pieces	No. lots tested	Cooking period	Losses					Remarks	
			Total Solids		Glucose as % of veg.	Total carbo- hydrate as % of veg.	Ash		
			as % of veg.	as % of solids in veg.			as % of veg.		as % of ash in veg.
Large	6	min.	4.19	17	0.35	-----	0.15	21	Satisfactory
	2	30	6.16	24	0.51	-----	0.20	30	
	2	60	8.07	30	0.69	-----	0.27	38	
	Cubes	4	15	4.66	19	0.40	-----	0.18	
Strips	4	15	6.04	24	0.43	-----	0.22	27	-----
Effect of acid hydrolysis of parsnip water									
Large	2	15	3.96	-----	0.30	3.13	-----	-----	-----
Cubes	2	15	4.51	-----	0.33	3.82	-----	-----	-----
Strips	2	15	5.99	-----	0.37	3.92	-----	-----	-----

TABLE 3

# WHITE TURNIPS—LOSSES IN COOKING USING 4 C.C. WATER TO 1 GM. VEGETABLE

Method of Preparation	No. lots tested	Cooking period	Losses					Remarks
			Total Solids		Reduc- ing sub- stances as % of veg.	Ash		
			as % of veg.	as % of solids in veg.		as % of veg.	as % of ash in veg.	
Cubes $\frac{3}{4}$ "	3	min.	%	%	%	%	%	..... ..... .....
	6	5	1.50	20.1	1.15	0.13	25.8	
	3	20	2.65	37.0	1.92	0.23	37.3	
		30	3.15	41.9	2.35	0.26	35.3	
Whole	1	20	1.61	21.2	1.29	0.13	28.3	.....
	2	30	1.66	21.2	1.11	0.18	32.7	Most Desirable
1½" cubes	1	20	1.62	21.6	1.04	0.17	27.0	.....
$\frac{3}{4}$ " cubes	4	20	2.61	34.2	1.84	0.23	41.7	.....
$\frac{3}{4}$ " cubes	Effect of varying the proportion of water							.....
2 water: 1 veg.	2	20	2.20	29.3	1.51	0.20	37.1	.....
4 water: 1 veg.	2	20	2.51	33.4	1.79	0.23	44.2	.....
8 water: 1 veg.	2	20	2.79	37.2	1.93	0.27	50.8	.....

TABLE 4

minutes to obtain the same degree of tenderness that one got in 20 minutes with the  $\frac{3}{4}$ " cubes, but in spite of the longer cooking the flavour was better.

Most of the quantitative work was done with  $\frac{3}{4}$ " cubes, and the results show that the losses are very great with even five minutes cooking—20% of the total solids and 25% of the mineral constituents, and that the losses increase until in 20 minutes over one-third of the solids of the vegetable are lost. This loss can be reduced by using 1½" cubes, or cooking the vegetable whole, and the latter seems the preferable method, the losses when boiling the whole turnips 30 minutes being considerably less than when the  $\frac{3}{4}$ " cubes were boiled 20 minutes. As the proportion of water was increased, so were the losses, but not very significantly, the results indicating that the size of the pieces affect the losses more than the ratio of water to vegetable.

## Green Beans

Green beans contain chlorophyll, which is readily destroyed by heat and acid. When the beans were first placed in boiling water they became bright green, but were all slightly brownish after boiling 20 minutes. Distilled

water impaired the colour more than the tap water did, but the amount of water made very little difference to the colour.

The preliminary tests showed that it required 20 minutes boiling to produce a palatable product whether the beans were cooked whole, broken into 1 inch pieces, or cut diagonally into "slivers" about one-eighth of an inch wide. After 15 minutes boiling the beans were easily pierced with a fork but had a slightly raw taste, and in fact although most of the tasters considered them sufficiently cooked after 20 minutes boiling, some preferred them after 25 to 30 minutes

boiling. After 35 minutes the flavour was greatly impaired.

The results as seen in Table 5 show that as the length of the cooking period increases from 5 to 60 minutes the

# GREEN STRING BEANS—LOSSES IN COOKING USING 4 C.C. WATER TO 1 GM. VEGETABLE

Method of Preparation	No. lots tested	Cooking period	Losses						Remarks
			Total Solids		Reducing substances as % of veg.	Ash			
			as % of veg.	as % of solids in veg.		as % of veg.	as % of ash in veg.		
Broken into approximately 1 inch pieces	2	min. 5	0.78	8.2	0.45	0.06	13.4	.....	
	4	20	1.54	15.7	0.89	0.12	25.0	.....	
	3	30	1.95	21.4	1.12	0.14	31.9	.....	
	1	60	2.34	25.7	1.23	0.21	41.2	Most palatable	
Whole	2	20	0.80	7.8	0.49	0.06	12.1	.....	
1" pieces	2	20	1.43	13.9	0.81	0.12	23.1	.....	
"Slivers"	1	20	3.22	32.9	1.75	0.24	50.0	.....	
Effect of varying the proportion of water—same two lots of vegetable for each test									
1" pieces 2 water: 1 veg.	2	20	1.26	12.6	0.73	0.09	20.6	.....	
1" pieces 4 water: 1 veg.	2	20	1.74	17.4	0.96	0.12	27.4	.....	
1" pieces 8 water: 1 veg.	2	20	1.89	18.9	1.10	0.13	31.4	.....	

TABLE 5

# LOSSES IN COOKING VEGETABLES TO GIVE MOST PALATABLE PRODUCTS, SIZE OF PIECES, PROPORTION OF WATER AND LENGTH OF COOKING

Vegetable	Size of pieces	Proportion of water to veg.	Cooking period	Losses					
				Total Solids		Reducing Substances		Ash	
				as % of veg.	as % of solids in veg.	as % of veg.	as % of solids lost	as % of veg.	as % of ash in veg.
White potato	cut in half crosswise	2:1	min. 20	0.78	3.4	0.053	7	0.18	19.4
Sweet potato	Whole	2:1	25	1.83	5.0	0.80	44	0.05	11.9
Parsnips	2½" x ¾"	3:1	15	4.19	17.0	*3.13	75	0.15	21.0
Yellow Turnips	quartered slices	4:1	45	4.29	.....	3.10	72	0.23	39.0
White turnips	Whole	4:1	30	1.66	21.2	1.12	67	0.18	30.0
Green beans	1"	4:1	20	1.54	15.7	0.89	58	0.12	25.0
Celery	1"	2:1	20	1.18	.....	0.28	24	0.13	25.0
Cauliflower	Flowerets	4:1	12	1.64	19.0	0.35	21	0.25	31.0
Cabbage	Shredded	4:1	7 to 9	2.73	.....	2.39	87	0.32	53.0

\*After hydrolysis.

TABLE 6

losses increase—total solids, reducing substances and ash. Using the same length of cooking period—20 minutes—and the same proportion of water to vegetable, the losses increase very significantly as one cooks the beans whole, or broken into 1 inch pieces, or cut into slivers. Increasing the water, but keeping all the other factors constant resulted in increased losses, but not to the same degree decreasing the size of the pieces. When the beans were cooked in two parts water to one of vegetable the flavour was somewhat strong and not as good as when a proportion of four to one was used, while the proportion of eight to one gave a rather tasteless product.

Tests were also made with



yellow turnips, cabbage, celery, and cauliflower, and similar results obtained. That is, the losses increased with the length of cooking, with the smallness of the pieces, and with the increased proportion of water.

In Table 6 is shown the size of pieces, proportion of water to vegetable, and the length of cooking that was considered most desirable for each of the nine vegetables studied. White potatoes were thought most desirable when cut in half crosswise and cooked for 20 minutes using twice as much water as vegetable, while the sweet potato was preferred cooked whole for 25 minutes.

It is rather interesting to compare the losses in these two types of potato—especially the glucose and ash. Sweet potatoes contain much more soluble carbohydrate than do ordinary white potatoes and the figures show the percentage loss of glucose in the sweet potatoes to be many times that of the white potatoes. Sweet potatoes, on the other hand, contain much less mineral matter than do white potatoes and we find that not only is the absolute mineral loss much smaller, but also the percentage loss. The distribution of ash in the sweet potato was not determined, but tests showed that in the white potato there is somewhat more mineral matter near the skin than in the interior, and this may partly account for the greater relative loss in the white potato. Tests made also showed that potatoes thinly pared contained 88% of the ash of the whole potato, as purchased, while when thickly pared, they contained only 74% of the ash of the original potato. In other words one lost an additional 14% of the total ash of the potato by taking a thick instead of a thin paring.

Parsnips were preferred when cut in large fingers  $2\frac{1}{2}$ " x  $\frac{3}{4}$ " and cooked 15 minutes in three times as much water as vegetable, while white turnips were preferred cooked whole for 30 minutes in four times as much water as vegetable. The same proportion of water was used for the yellow turnips, but they required about 45 minutes cooking when cut in half inch slices, pared and quartered. Yellow turnips are usually served mashed and it requires a somewhat longer cooking to make the mashed product

smooth and attractive, than would be necessary if the vegetable were served in cubes. Parsnips and turnips are both root vegetables, but they differ greatly in their content of solid material. On an average the edible portion of parsnips contains about 20% of solids and 80% of water while yellow turnips contain roughly only 10% of solids and 90% of water, and white turnips somewhat less than 10% solids. It is noticeable that with these three vege-

(Continued on page 29)

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# Removal of Tariff on X-ray Equipment Requested

## Canadian Hospital Council Makes Request to Ottawa

The Executive Committee of the Canadian Hospital Council, after further consideration of the X-ray situation in Canada, has authorized the Secretary to forward the following letter to the Honourable the Minister of Finance. This letter was accompanied by resolutions, requesting the restoration of the former free entry of X-ray equipment, passed by a number of hospital associations during the past year.

"The Honourable  
Mr. C. A. Dunning,  
Minister of Finance,  
Ottawa, Canada.

November 25th, 1936.

Re: *British Preferential Treaty*

Dear Mr. Dunning:

On behalf of the Canadian Hospital Council the following representations are made with respect to any possible revisions in the Treaty at the expiration in 1937 of the initial five-year period.

It will have been noted that the hospitals and the medical profession of Canada, as an evidence of their support of the movement towards greater Empire trade, accepted with good grace the loss of their ability to make free importation of surgical and X-ray equipment under Tariff Item 476. Protest at that time by the Canadian Hospital Council, although voiced, was not pressed and at subsequent meetings of the Council, representatives from the various provincial hospital associations have repeatedly expressed their desire to co-operate, if possible, in this movement. More British surgical instruments have been purchased and British X-ray films (Ilford) are now widely used. In connection with the importation of X-ray apparatus, however, the Treaty has proven to be a distinct hardship to our hospitals, all of which, with a few small exceptions, operate on a charitable non-profit basis.

"Despite a ten per cent advantage, the importations of British X-ray equipment have been almost negligible. In a communication, dated August 15th, 1935, H. M. Senior Trade Commissioner in Canada informed us that, according to his records, only one hospital had made a purchase and that was but of an accessory unit costing about \$1,100 or \$1,200. During that period, Canadian hospitals have imported many hundreds of thousands of dollars worth of X-ray equipment, mostly from two or three outstanding manufacturers in the United States, and some from France and Germany. On this equipment the ten per cent customs tariff has been paid.

"The reason for this situation is largely the problem of *service*. Almost any reliable make of X-ray equip-

ment will work when installed, but, as lives depend upon the efficiency of this apparatus and, as breakdowns or the need for replacements are frequent, it is absolutely essential to the public interest that both replacements and highly skilled repair technicians be available on short notice. Many hospital directors, thoroughly sympathetic with the Empire Treaty arrangements, have felt compelled to purchase non-British equipment and pay the tariff charges for the sole reason that such other manufacturers have established adequately equipped and staffed *service* agencies in strategic centres across Canada, while the British houses, despite four years of opportunity, have not done so to any appreciable extent. An agency in Toronto (Solus—now Ferranti Electric Ltd.) and the recent establishment of one by another company in Montreal (Messrs. Philips Metalix Ltd. of Canada) can service such local areas, but are quite inadequate to service the Maritime provinces or the entire western field.

"X-ray tubes (Andrews) have been sold to a slight degree. Messrs. Fisher and Burpe of Winnipeg are the Canadian representatives.

"In the X-ray field, British houses are up against very severe competition, and our hospitals do not seem to be convinced of the superiority of their products. This may be because of a comparatively feeble advertising policy, but, it is noted that X-ray importations are unusually high in Great Britain itself.

"It is obvious, therefore, that the present arrangement is of practically no value to the British X-ray firms, and yet has required our hospitals to divert money from their increasing amount of charity work to pay this additional tariff. The hospitals have tried to further Imperial trade, have purchased British instruments, for example, although at higher cost, but we see no possibility of an extensive market here for British X-ray equipment under present conditions. In making this statement, we wish to make it clear that we do not in any way desire to embarrass the Government in its desire to foster Imperial trade. Our sole object is to make our position clear, and to point out the futility of the present X-ray arrangements. Certain resolutions are appended.

Yours sincerely,

(Sgd.) Harvey Agnew, Secretary,

GHA:M

CANADIAN HOSPITAL COUNCIL."

Despite a rumor to the contrary, the 10% Customs Tariff on non-British X-ray importations is still in force, according to a letter dated December the 22nd, 1936.

The CANADIAN HOSPITAL

## Losses in Cooking Vegetables

(Continued from page 27)

tables the reducing substances account for from  $\frac{2}{3}$  to  $\frac{3}{4}$  of the total losses.

The other four vegetables grow above ground. The green beans and celery were considered most palatable when broken into one inch pieces and cooked 20 minutes, the beans in four parts of water to one of vegetable and the celery in only twice as much water as vegetable. The cauliflower was preferred broken into large flowerets, and the cabbage shredded and cooked in four times as much water as vegetable, the cauliflower for 12 minutes and the cabbage from 7 to 9 minutes. When boiled only 5 minutes the cabbage was considered somewhat undercooked, but was overcooked when boiled for more than 10 minutes.

The total solids in cabbage was not estimated, but the average given in the latest table gives 92.4% water and 7.6% solids. Using this average figure the cabbage cooked here lost 36% of its total solid material—much the highest of any of the vegetables studied. This fits in with our findings that the size of the piece is in general a more important factor in determining the losses than either the length of cooking or the proportion of water.

## The Canadian Dietetic Association

### Payment of Membership Fees

Many members are in arrears. The Treasurer, Miss K. L. Jeffs, The T. Eaton Company, Ltd., Montreal, will be glad to receive the Annual Fee of \$1.00 and also notification of any change in address.

### Application for Membership

Application should be made to the chairman of the Membership Committee, Miss Gladys Martin, 61 Charles Street, East, Toronto. Please do not send fee until notified of acceptance by the Executive Committee.

## Our Hospitals

When one recalls the origin of the various factors that have forced forward the hospitalization of the sick, one feels as if its progress was irresistible. Its roots extend farther and sink deeper year by year. There is no concept, no activity of modern life so far reaching, so tied up with modern progress and betterment as is the care of the sick.

The popularity of the hospital movement increases year by year. Everyone is interested in the hospital. The hospital is always news. In it occur the miracle of birth and the tragedies of sickness. News incidents about the hospital receive space in the local press far beyond that of any other institution. The hospital is also tremendously susceptible to criticism, not because it is inefficiently operated, but because of its tremendous responsibility. It is entrusted with life and death. The care of the sick and loved ones is a very personal matter with the public. Negligence, inefficiency or waste, which may go unnoticed in other organizations and activities, are not tolerated in hospitals by the public.—R. G. Ferguson, M.D., Presidential Address, Saskatchewan Hospital Association.



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# WE WOULD LIKE TO KNOW—

*The Editorial Board will be pleased to answer in this column any question they can that will be of general interest to hospital workers. Kindly mail questions directly to the Editor.*

**Q. What do you recommend for removing stains and particles of food baked on dishes and not removed by ordinary dishwashing process?**

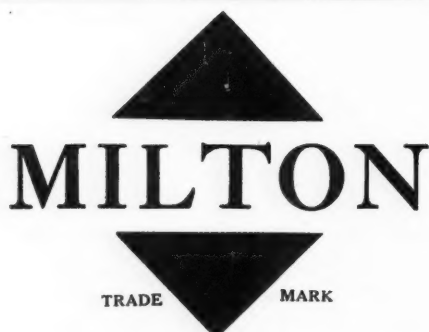
A. Immerse the dishes for about 30 seconds in the following solution: Dishwashing Cleanser, 1 pound; Chlorinated lime, 1 pound; Water, 1 gal. This solution requires frequent stirring. After immersion wash the dishes in usual manner. The solution is harmless to the dishwasher's hands but should not be used to clean silverware as it discolours metal.

**Q. Can you give us a good method of marking hospital rubber goods?**

A. Paint distinguishing marks on rubber goods with a 10% solution of silver nitrate applied on a swab or with camel hair brush. Do not use a silver nitrate pencil. The article can be used as soon as the solution is dry.

**Q. How do you remove balsam of peru stains from linen?**

A. These stains can be easily and completely removed by brushing the linen with commercial oleic acid and allowing it to remain on the linen for approximately an hour then rinse in a well diluted solution of ammonia. The most frequent cause of failure by this method is due to an insufficient time being allowed the oleic acid to act.



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**Q. What regulations can be made by a hospital to control ritual circumcision?**

A. It is the duty of the hospital to allow such circumcision to be done by rabbis at the request of the parents of the child. Any opposition to this procedure is a curtailment of religious rites and will react harmfully against the hospital, but in protection of the patient the hospital has every right and must exercise such right in demanding that a careful technique be observed, that is, the one who operates should be required to scrub for the same length of time that a surgeon would and must wear gowns and gloves, etc., in fact, must use identical technique as that of a surgeon, furthermore, the instruments must be sterilized in the usual manner. Either the patient's family doctor or the resident of the hospital must be in attendance during the circumcision. Also, the hospital has the right to say where and when the operation should be performed although as far as the time is concerned it should co-operate to the extent that the effectiveness of the rites are not interfered with. In smaller communities the hospital can do good work by offering to prepare sterile outfits for the rabbi so that he may use these in places other than the

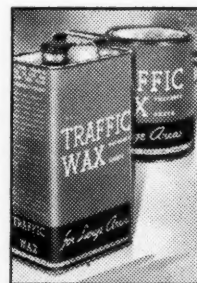
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hospital, such a gesture on the part of the hospital will be appreciated and can be considered as part of its educational policy.

**Q. Is it usual to charge employees who become sick for their hospitalization?**

A. This is a matter of individual hospital policy although it would probably be to the advantage of hospitals if a standard procedure were created. Some hospitals look after their employees during any type of illness without charge, others consider only those employees who have become sick due to their employment, while several hospitals give discounts. Any hospital in protection for itself should be very careful to have a physical examination conducted at the time that an application for employment is made otherwise there is a tendency for people to get on the staff of the hospital and take advantage of either free hospitalization or reduced rates as the case may be to have chronic conditions remedied. Another method to prevent such a possibility would be to charge the full amount for hospitalization for a certain period of time after employment commences except in cases of injury or sickness due to employment. MacEachern in "Hospital Organization and Management", Page 837, states: "Sick and injured employees. (a) Employees who are injured or become sick as a result of their employment will be given the necessary hospital and medical care without cost and will be compensated in accordance with the workman's compensation laws of the state (province). (b) Employees who are injured or become sick from non-compensable causes will be given hospital service at cost and will be cared for by the medical staff (insert whatever arrangement the medical staff is willing to make). In the case of such injury or illness the employee will not be entitled to any compensation."

**Q. What disciplinary relationship should exist between supervisors and interns?**

A. The supervisor is in charge of the ward or floor and as such any person or persons working on that floor, which includes interns, shall be subservient to her in administrative matters. In medical matters the intern will be expected to co-operate with the supervisor and vice versa.

**Q. We find the depreciation on gloves and surgical dressings very heavy due to sterilization. The quality of material has been checked and found to be up to standard and the operating room nurse claims that over-sterilization does not take place. Both dressings and gloves become discolored after one or two sterilizations. (50 bed hospital).**

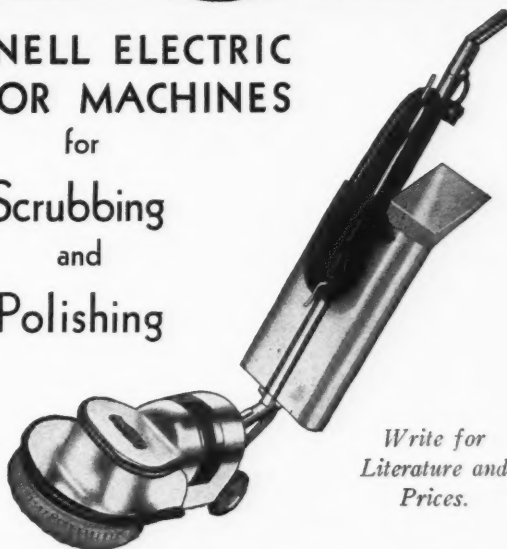
A. Unless you have a definite mechanical means such as a time clock with mechanical recording we are inclined to think that the problem is one of over-sterilization. Your statement of discoloration bears this out. You would be wise to have the gauges of your sterilizer checked to see that they are not recording low and thereby causing you to sterilize at a higher pressure and higher temperature than necessary. When this has been done take a sample kit of new material placing individual controls in the packages, place them loosely in the sterilizer and run through a number of sterilizations at recommended times. It is more than likely that you will find discoloration does not take place. As you speak of several sterilizations for dressings we presume you use reclaimed gauze, is it possible that such discoloration may be due to staining of this gauze in previous usage?

JANUARY, 1937

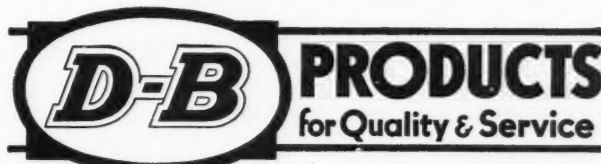
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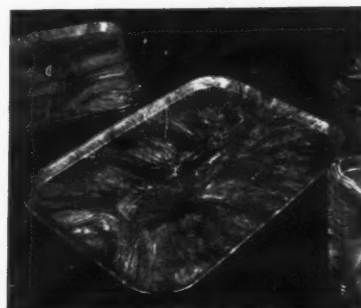
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# Here and There in the Hospital Field

By HARVEY AGNEW, M.D.,

Secretary, Canadian Hospital Council

ALBERTA.—Mr. W. A. Shoults has been appointed Supervisor of Hospitals in the Province of Alberta to succeed Mr. W. B. Milne, who has been head of the Municipal Hospitals Supervision Branch for the past eight years, and has also held the position of Secretary of the Provisional Department of Health. Mr. Milne is leaving for England, where he will study art.

\* \* \*

ALBERTA.—The use of pasteurized milk by hospitals, where pasteurization facilities are available, was unanimously recommended in a resolution passed at the recent meeting of the Alberta Hospital Association. The resolution, which was moved by Dr. A. E. Archer, referred to the well-known fact that unpasteurized milk is a factor in transmitting infection and communicable disease and that pasteurization does not materially affect the quality of the milk or its vitamin content.

\* \* \*

BRITISH COLUMBIA.—Realizing the importance of bibliography, or the use of selected reading material, in the care of the patient, a committee was appointed by the British Columbia Hospitals Association at its recent meet-

ing to work in conjunction with a similar group from the British Columbia Library Association, and, if necessary, with the Provincial Government to consider the possibility of setting up a demonstration hospital library along lines somewhat similar to those of the rural libraries.

\* \* \*

DIGBY, N.S.—A small fire occurred in the basement of the Digby General Hospital a few weeks ago. This was from spontaneous combustion in the coal bin; damage was slight.

\* \* \*

MADRID.—The Canadian Medical Mission, under Doctor Norman Bethune, has been placed in charge of the blood transfusion service for the entire Madrid area by the Spanish Government. There will be a staff of ten and a list of several hundred blood donors. A central medical station, where the blood donors give their blood will maintain communications with the different hospitals and ambulances. A special blood transfusion car will carry the blood and the doctor in charge wherever needed. This car is fully equipped with sterilizer, refrigeration plant and the necessary surgical equipment.

\* \* \*

MOUNT FOREST, ONT.—On November the 12th a bronze plaque in memory of the late Mr. and Mrs. Wentworth G. Marshall, was unveiled at the Louise Marshall Hospital. Doctor F. W. Routley, Secretary of the Ontario Hospital Association was guest speaker.

\* \* \*

ONTARIO.—Certain mental patients of from 15 to 20 years are to be allowed to support themselves by domestic labour in approved homes, according to an announcement recently made.

\* \* \*

QUEBEC.—Early organization, into one body, of all departments of hygiene and health in the Province of Quebec was predicted recently by Mr. J. H. A. Paquette, Provincial Secretary. The thirty-five health units in the province will be increased in number, so that there will be units in all districts of the province. An early investigation into the admission of indigents into various institutions was announced. The replacement of nurses, at colonization centres, by young doctors was also forecast

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by Doctor Paquette, the government being ready to pay \$100 a month to young doctors desiring to accept positions.

\* \* \*

TORONTO, ONT.—The general distribution of protamine insulin by the Connaught Laboratories is anticipated early in the new year. This has been available for some months in experimental quantities, and its enthusiastic reception by the profession, because of its efficiency and its comparative ease of administration, augers well for its widespread use, when distribution becomes general.

\* \* \*

TORONTO, ONT.—The establishment of birth control clinics in connection with hospitals, especially in all tuberculosis institutions, and the inclusion of instruction on the subject in nursing school curricula are among the activities being considered by the recently formed Toronto League for Race Betterment. This organization, which is sponsored by a group of prominent citizens of Toronto, aims to provide education with respect to the birth control movement and racial benefit, to encourage establishment of properly supervised centers and clinics and to investigate all sociological and scientific data bearing on the sterilization of the mentally unfit.

\* \* \*

VICTORIA, B.C.—The Advisory Board of the British Columbia Farmers' Institutes, at its recent session, requested that the health insurance plan be extended to include agricultural workers.

#### Construction

BRANTFORD, ONT.—On December 7th, the Brantford Ratepayers by a large majority authorized a \$100,000 extension to the Brantford General Hospital for Isolation and other purposes.

\* \* \*

Carmangay, Alta.—Organization of the Little Bow Municipal Hospital district has been authorized, and a vote will be taken shortly to consider the erection of a 15-bed hospital. The proposal is meeting with some opposition from the municipality of Little Bow. A counter petition has been circulated, and has been extensively signed in certain areas.

\* \* \*

Goderich, Ont.—The proposed \$6,000 additional storey to the south wing of the Alexandra Marine and General Hospital will be started next spring. Mr. L. G. Bridgman of London, is the architect. The proposal is to add 6 rooms, 3 being double and 3 single. These rooms would be used for the accommodation of nurses, thus freeing other space for patients.

\* \* \*

Lake Windermere, B.C.—The Honourable and Mrs. Bruce have offered their former home "Pynelogs" in Invermere as a new hospital for the Windermere district. They have offered to remodel and equip the building as a hospital as part of the gift. The offer was unanimously accepted, and the new hospital will be called the "Lady Elizabeth Bruce Memorial Hospital".



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MONTREAL

London, Ont.—Subcontracts have been let for the building of Pavilion "C" at Westminster Hospital. Architects are Mr. William G. Murray and Mr. D. M. Hennigar.

\* \* \*

Norfolk, Ont.—The Norfolk County Council has asked the Norfolk General Hospital to take over the former Children's Shelter building and refit it as a Maternity Hospital.

\* \* \*

Oshawa, Ont.—The proposed expansion of the Oshawa General Hospital has not as yet been announced, but it is anticipated that early decision will be made and construction begin in the near future.

#### **\$25,000 Bequest to Picton Hospital**

The Prince Edward County Hospital at Picton, Ontario, has received a bequest of \$25,000 from the estate of the late Mrs. Susan Neer, a former resident of Prince Edward County, who died recently from the effects of a motor accident.

### **Department of Medicine**

In the growth of specialization, medicine has not been so sharply divided into specialties as has surgery, and as a consequence the medical subdivisions in the hospital are not so numerous or distinct. Specialization in the care of tuberculosis of the lungs, nervous and mental, and communicable diseases has resulted in definite departments or special hospitals for their treatment; but because other medical conditions are not so readily divided into specialties they are only occasionally treated in special departments or hospitals.

An important factor in the treatment of patients in the medical service is the extreme co-operation with the physician which must be developed by the nursing and dietary services. The weighed and measured diet ordered by the physician is prepared by the dietitian and served by the nurse, and, in addition, unconsumed food must be either weighed and measured by the nurse or returned to the dietitian to enable her to determine the amount consumed. Frequently, it is necessary to determine the output, as for example when the 24-hour measured specimen of urine is taken for laboratory examination.

The medical nurse must be interested in her profession and capable of impressing on her subordinates and associates the necessity for unceasing attention to infinite detail; she must have a knowledge of the requirements for nursing care of the various medical diseases which she will contact in her work. Medical nursing is in itself a specialty, inasmuch as many diseases and conditions have aspects requiring more than ordinary nursing skill. The patient with pneumonia or a cardiac condition requires a much different type of nursing from that given the patient with anemia, diabetes, or nephritis.

As a result of investigation and research in various branches of medicine, certain distinct specialties have been developed and are being recognized to-day, specialties which are frequently limited to specific organs of the body.

#### **SUPERINTENDENT, OR SUPERINTENDENT OF NURSES, AVAILABLE**

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#### **X-RAY TECHNICIAN, EXPERIENCED, NOW AVAILABLE**

Desires connection with clinic or large or small hospital; full or part time; also relief engagements. Will also accept clinical laboratory and physiotherapy duties. Male, 43, single, Protestant. Copies of references on request. Used to any make of equipment. Write early, in care of Box No. W. 131, Canadian Hospital, 177 Jarvis St., Toronto.

#### **TECHNICIAN, LABORATORY AND X-RAY**

Desires position in hospital in Ontario, extensive experience in large hospital. Used to any make of equipment. Am also graduate dispenser, O. C. P. Male, 32, Married. Box R 121. The Canadian Hospital, 177 Jarvis St., Toronto.

#### **Interesting Dishwasher Installation**

More and more are hospitals becoming alive to the importance of proper cleansing of their tableware. Isolation Hospitals in particular are aware of the part that sterilized dishes play in combating this menace.

A recent installation of interest to hospital executives is one at Laval Hospital, Ste. Foye, P.Q., where eight Hobart Dishwashers were supplied for use in the various ward kitchens. The model furnished was the Hobart SM-2, a compact, stainless steel machine which occupies little space and yet adequately takes care of general requirements. A unique feature of these machines is a steam sterilizing device built into each machine so that each piece is sterilized as it is washed.

Hobart Dishwashers are based on the Crescent Machines, a line absorbed by the Hobart organization several years ago. Widely and favorably known to kitchen operators throughout Canada, the Hobart line of electric Kitchen Equipment includes Mixers, Potato Peelers, Meat and Bread Slicers, Food Cutters, Air Whips, Meat Grinders, Coffee Mills and the recently acquired line of Dayton Scales.

#### **Seasonal Gift for Employees of Stewart-Warner-Alemite**

W. E. Rowsome, General Manager of the Stewart-Warner-Alemite Corporation of Canada, Limited, announced before Christmas the decision of the Company to present to each of its employees who have been with the Company for one year or more a special Seasonal gift equivalent to one full week's salary. This move, states Mr. Rowsome, is in keeping with the firm's settled policy to share the benefits of better times with the office staff and factory workers.

During the heat of the summer, Stewart-Warner-Alemite factory employees also received one week's holidays with full pay. This, in addition to the current gift, applied to the entire plant, including the three Divisions of Alemite Lubricating Systems and Equipment, Stewart-Warner Radio and Bassick Casters.